bright grey®

Protection. We make it personal

Business Protection Menu application form (July 2011)

Please answer all of the questions on this form honestly and in full. If you miss any information out, or give us misleading information, this could mean that we do not pay your claim. This could also delay the processing of your application.

Important information for financial advisers

Please remind your client how important it is to answer all the questions on this form honestly and in full.

quote number

Please give us the quote number and attach the quote. This helps us process the application more quickly

adviser name

adviser's company name

This is the company we will process this application for.

account number

If you know your Bright Grey agency account number please tell us.

special commission instructions

Please tell us any special commission instructions such as non-indemnity.

company address

postcode

telephone

fax

email

your unique reference

If you would like us to use a reference for future correspondence, please write your unique reference here.

Important information for customers

It is very important that you tell us if there is a change to your health, occupation or leisure activities between completing this form and the date we assume risk on your plan.

If you have had a genetic test, you only have to tell us the results if this application, when added together with any cover you have of the same type, is for more than:

- £500,000 of Life Cover;
- £300,000 of Critical Illness Cover or Life or Critical Illness Cover; or
- £30,000 each year of Income Cover for Sickness.

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

Please note: if your plan is not in force 6 months after the date you sign this form we will request a new application form.

Completed forms should be returned to:
Bright Grey
2 Queen Street
Edinburgh, EH2 1BG

Financial adviser use only

Please DO NOT complete this section if you are attaching a quote.

	Life Cover	Life or Critical Illness Cover	Critical Illness Cover	Income Cover for Sickness	Key Person Income Cover for Sickness	Payment Cover for Sickness If you want Income Cover for Sickness or Payment Cover for Sickness you must complete this column.
Amount of cover						
Lump sum or Yearly income	£	£	£	£	£	
Which person						
First person	○	○	○	○	○	○
Second person	○	○	○	○	○	○
Joint life first event	○	○	○			○
Term of cover						
Fixed term	1-40 years	1-40 years	5-40 years	5-40 years	5-20 years	
5 year renewable	○	○	○			
Payment of cover						
Level lump sum	○	○	○			
Level income				○	○	
Increasing lump sum	○	○	○			
Increasing income				○	○	
Increase rate (2-5%)	%	%	%	%	%	
or RPI	○	○	○	○	○	
Decreasing lump sum	○	○	○			
Interest rate (0-15%)	%	%	%			
Decreasing frequency	○ monthly ○ yearly	○ monthly ○ yearly	○ monthly ○ yearly			
Whether payments change or not						
Guaranteed payments	☑	○		☑	☑	☑
Reviewable after 5 years		○	☑			
Definition of disability/incapacity						
Own occupation		○ Person 1 ○ Person 2	○ Person 1 ○ Person 2	○ Person 1 ○ Person 2	○ Person 1 ○ Person 2	○ Person 1 ○ Person 2
Working tasks		○ Person 1 ○ Person 2	○ Person 1 ○ Person 2	○ Person 1 ○ Person 2	○ Person 1 ○ Person 2	○ Person 1 ○ Person 2
Deferred period						
4 weeks				○	○	○
13 weeks				○	○	○
26 weeks				○	○	○
52 weeks				○	○	○
Cover payment period						
Throughout				○		
1 year				○	○	
2 years				○	○	
3 years					○	
4 years					○	
5 years					○	

Total payment £

Financial adviser use only – Important information about this application form

Please tell us what this application form is for by ticking the relevant box(es) below:

○ Business Protection Menu only
○ Application to replace an existing application form that is out of date (i.e. completed over 6 months ago)
○ Alteration to an existing plan

About the plan(s)

If you are applying for more than one plan please tick all boxes that apply.

Please attach a separate quote for each plan.

Plan 1	**Quote number**
1 What is the purpose of this plan?	○ **Key person** ○ **Shareholder/partnership protection** ○ **Loan protection** ○ **Relevant life cover**
2 Who will own this plan*? (Please tick one only) * If the plan will be relevant life cover, or if it's to be used for company share purchase or life of another key person cover, you must only tick the 'Other applicant' box.	○ **Person 1** ○ **Person 2** ○ **Person 1 and 2** ○ **Other applicant**
3 Will the plan be written under trust? (Tick relevant box)	○ **Business trust** ○ **Relevant life trust** ○ **Split trust** ○ **No trust**

If the person/people covered require more than one plan, please provide details of the appropriate plans below:

Plan 2	**Quote number**
4 What is the purpose of this plan?	○ **Key person** ○ **Shareholder/partnership protection** ○ **Loan protection** ○ **Relevant life cover**
5 Who will own this plan*? (Please tick one only) * If the plan will be relevant life cover, or if it's to be used for company share purchase or life of another key person cover, you must only tick the 'Other applicant' box.	○ **Person 1** ○ **Person 2** ○ **Person 1 and 2** ○ **Other applicant**
6 Will the plan be written under trust? (Tick relevant box)	○ **Business trust** ○ **Relevant life trust** ○ **Split trust** ○ **No trust**

Plan 3	**Quote number**
7 What is the purpose of this plan?	○ **Key person** ○ **Shareholder/partnership protection** ○ **Loan protection** ○ **Relevant life cover**
8 Who will own this plan*? (Please tick one only) * If the plan will be relevant life cover, or if it's to be used for company share purchase or life of another key person cover, you must only tick the 'Other applicant' box.	○ **Person 1** ○ **Person 2** ○ **Person 1 and 2** ○ **Other applicant**
9 Will the plan be written under trust? (Tick relevant box)	○ **Business trust** ○ **Relevant life trust** ○ **Split trust** ○ **No trust**

If you have shown that the 'Other applicant' will own this plan, please complete the next page and sign in the 'Other applicant' signature box on page 29.

About the other applicant

Complete this page if:

The plan will be:
- **relevant life cover**
- **used for company share purchase**
- **life of another key person cover**

or

If any person or business applying for the plan is not the same as the person covered.

	Other applicant
1 Other applicant's full name If the other applicant is a company, please give the registered name of the company	
2 Other applicant's date of birth (if applicable)	/ /
3 What is the other applicant's relationship to the person or people covered?	**Person 1** ○ Self ○ Business partner ○ Co-shareholder ○ Employer ○ Other If Other, please give full details. **Person 2** ○ Self ○ Business partner ○ Co-shareholder ○ Employer ○ Other If Other, please give full details.
4 In which country is the other applicant permanently resident? If the other applicant is a company, in which country is their registered address located?	○ UK ○ Jersey ○ Guernsey ○ Isle of Man ○ Other
5 In the next 6 months will the other applicant be moving from the country in which they are permanently resident?	○ No ○ Yes If Yes, please give full details.
6 What is the other applicant's address?	house name house/building number street name town/city county country postcode

If you have completed this part of the application form, you must sign and date the declaration page under 'Other applicant' on page 29.

Section A – About the people covered

	Person 1	Person 2
1 Your name	title first name middle name last name	title first name middle name last name
2 Your home address Please only give us your current address. If you move house while we are processing your application, please contact us once you have moved to your new address.	house name house number street name town/city county country postcode phone daytime phone evening mobile email	house name house number street name town/city county country postcode phone daytime phone evening mobile email
3 Date of birth	/ /	/ /
4 Sex	○ Male ○ Female	○ Male ○ Female
5 Marital status	○ Married ○ Living together as partners ○ Divorced ○ Widowed ○ Single ○ Separated ○ Civil partnership ○ Surviving civil partner	○ Married ○ Living together as partners ○ Divorced ○ Widowed ○ Single ○ Separated ○ Civil partnership ○ Surviving civil partner
6 What is your relationship to Person 1?		○ Co-director ○ Business partner ○ Other If Other, please give full details.
7 When do you want this plan to start?	○ I will tell you later ○ On the date I tell you below / /	
8 Do you have an existing plan or application with Bright Grey? **If Yes, please give us the plan/application number.**	○ No ○ Yes	○ No ○ Yes
Is this existing plan being replaced by this application?	○ No ○ Yes	○ No ○ Yes

If you need to tell us about more plans, please use page 33.

Section A continued

	Person 1	Person 2
9 Including this application to Bright Grey, will the total amount of insurance cover you have on the person covered, or are currently applying for, with all insurance companies be higher than **– £750,000 of Life Cover or** **– £400,000 of Critical Illness Cover?**	○ **No** ○ **Yes** If Yes, please give us details of all plans you have on the person covered, or are applying for, with other companies.	○ **No** ○ **Yes** If Yes, please give us details of all plans you have on the person covered, or are applying for, with other companies.
Cover 1 **What is the cover for?**	○ **Life Cover** ○ **Critical Illness Cover** ○ **Life or Critical Illness Cover**	○ **Life Cover** ○ **Critical Illness Cover** ○ **Life or Critical Illness Cover**
What is the reason for the cover?	○ **Key person** ○ **Key person loan** ○ **Shareholder/partnership protection** ○ **Sole trader** ○ **Other**	○ **Key person** ○ **Key person loan** ○ **Shareholder/partnership protection** ○ **Sole trader** ○ **Other**
What is the amount of the cover?		
At claim, will the cover be paid as a lump sum or income?	○ **Lump sum** ○ **Income**	○ **Lump sum** ○ **Income**
What is the remaining term of the cover?		
Do you intend to cancel this cover when your Bright Grey plan starts?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
Cover 2 **What is the cover for?**	○ **Life Cover** ○ **Critical Illness Cover** ○ **Life or Critical Illness Cover**	○ **Life Cover** ○ **Critical Illness Cover** ○ **Life or Critical Illness Cover**
What is the reason for the cover?	○ **Key person** ○ **Key person loan** ○ **Shareholder/partnership protection** ○ **Sole trader** ○ **Other**	○ **Key person** ○ **Key person loan** ○ **Shareholder/partnership protection** ○ **Sole trader** ○ **Other**
What is the amount of the cover?		
At claim, will the cover be paid as a lump sum or income?	○ **Lump sum** ○ **Income**	○ **Lump sum** ○ **Income**
What is the remaining term of the cover?		
Do you intend to cancel this cover when your Bright Grey plan starts?	○ **No** ○ **Yes**	○ **No** ○ **Yes**

If you need to tell us about more covers, please use page 33.

Section A continued

	Person 1	Person 2
10 Do you have, or are you making an application for, any other income protection, mortgage payment protection insurance or accident and sickness cover plan?	○ No ○ Yes If Yes, please give us details of all plans you have on the person covered, or are applying for, with other companies.	○ No ○ Yes If Yes, please give us details of all plans you have on the person covered, or are applying for, with other companies.
Cover 1 **What is the cover for?**	○ Income protection ○ Mortgage payment protection insurance ○ Accident and sickness	○ Income protection ○ Mortgage payment protection insurance ○ Accident and sickness
What is the amount of the cover?		
At claim, what is the deferred period before payment is made?		
At claim, what is the payment period of the cover?		
Do you intend to cancel this cover when your Bright Grey plan starts?	○ No ○ Yes	○ No ○ Yes
Cover 2 **What is the cover for?**	○ Income protection ○ Mortgage payment protection insurance ○ Accident and sickness	○ Income protection ○ Mortgage payment protection insurance ○ Accident and sickness
What is the amount of the cover?		
At claim, what is the deferred period before payment is made?		
At claim, what is the payment period of the cover?		
Do you intend to cancel this cover when your Bright Grey plan starts?	○ No ○ Yes	○ No ○ Yes
If you are unable to work because of an illness or an accident will you continue to receive an income from your employment or self-employment? **If Yes, please tell us** **– the monthly amount you will receive or the percentage of your earnings this represents, and** **– how long you will continue to receive an income.**	○ No ○ Yes £ or % years months	○ No ○ Yes £ or % years months

If you need to tell us about more covers, please use page 33.

	Person 1	Person 2
11 Have you ever had an application on your life accepted on special terms, deferred or declined? If Yes, please tell us the decision, date of decision and company name.	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.

Section B – Your job

	Person 1	Person 2
1 Your job title		
2 What industry do you work in?	○ Armed forces ○ Aviation ○ Construction ○ Demolition ○ Diving ○ Docks ○ Fishing ○ Merchant marine ○ Mining/tunnelling ○ Oil/gas rigs offshore ○ Quarrying ○ Railways ○ Ship building or repair ○ None of the above	○ Armed forces ○ Aviation ○ Construction ○ Demolition ○ Diving ○ Docks ○ Fishing ○ Merchant marine ○ Mining/tunnelling ○ Oil/gas rigs offshore ○ Quarrying ○ Railways ○ Ship building or repair ○ None of the above
3 Does your job involve working at heights?	○ No ○ Yes If Yes, please tell us how often you work at heights. ○ Daily ○ Once or twice a week ○ Once or twice a month ○ Less than once or twice a month Please tell us the highest and average heights you work at. highest average	○ No ○ Yes If Yes, please tell us how often you work at heights. ○ Daily ○ Once or twice a week ○ Once or twice a month ○ Less than once or twice a month Please tell us the highest and average heights you work at. highest average
4 Does your job involve hazardous duties? e.g. working with explosives or handling asbestos.	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.
5 Are you a member of the Territorial Army (TA) or Armed Forces reservists?	○ No ○ Yes	○ No ○ Yes
6 What are your gross annual earnings from your employment? If self-employed, what are your net taxable earnings after allowable deductions? Please answer this question for all covers.	£	£
7 What is your employment status?	○ Salaried employee ○ Self-employed	○ Salaried employee ○ Self-employed

Section B continued

Please answer questions 8 and 9 if you are applying for: Waiver – Payment Cover for Sickness, Life or Critical Illness Cover, Critical Illness Cover or Income Cover for Sickness.

Question	Person 1	Person 2
8 Approximately what percentage of time do you spend each week on these activities? Remember to answer this question if you are applying for Payment Cover for Sickness (waiver).	**administrative or office duties %** **manual or physical work %** **driving (excluding commuting) %** **total 100%** If your work includes manual or physical work, please give full details of the tasks. If your work includes driving, what is your average annual mileage? **miles**	**administrative or office duties %** **manual or physical work %** **driving (excluding commuting) %** **total 100%** If your work includes manual or physical work, please give full details of the tasks. If your work includes driving, what is your average annual mileage? **miles**
9 How many hours a week do you work on average? Please exclude commuting and on-call time. Remember to answer this question if you are applying for Payment Cover for Sickness (waiver).	**hours per week**	**hours per week**

Section C – Residency and travel

	Person 1	Person 2
1 In which country are you permanently resident?	○ UK ○ Jersey ○ Guernsey ○ Isle of Man ○ Other	○ UK ○ Jersey ○ Guernsey ○ Isle of Man ○ Other
2 In the next 6 months, will you be moving from the country in which you are permanently resident?	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.
3 Have you lived outside the UK or outside one of the countries listed below for more than 6 months in the last 2 years? If Yes, please tell us the name of the country you lived in, how long you stayed and the reason for your move.	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.

Australia, Austria, Belgium, Canada, Channel Islands, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, The Netherlands, New Zealand, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland and the USA.

	Person 1	Person 2
4 Other than holidays of less than 3 months, have you any intention of going outside the UK or outside one of the countries listed above? If Yes, please tell us about the number of visits, the countries you will visit, how long you will stay, and the reasons for the trips.	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.

Section D – Hazardous leisure activities

	Person 1	Person 2
1 Do you take part in any hazardous leisure activity? e.g. private aviation, diving, yachting or sailing, mountaineering or rock-climbing, motor sports, caving or potholing, parachuting, hang-gliding. Do not include one-off events, such as a parachute jump for charity.	○ No ○ Yes If Yes, please give full details.	○ No ○ Yes If Yes, please give full details.

Section E – Your lifestyle

Question	Person 1	Person 2
1 What is your height? You can use either feet and inches or metres and centimetres.	feet / inches metres / centimetres	feet / inches metres / centimetres
2 What is your weight? You can use either stones and pounds or kilos.	stones / pounds kilos	stones / pounds kilos
3 In the last 3 months, has your weight increased or decreased by 7 pounds (3 kgs) or more, for reasons other than stopping smoking, pregnancy or dieting?	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.
4 How many units of alcohol do you drink in an average week? 1 pint of beer = 2 units; 1 glass of wine (175ml) = 2 units; 1 measure of spirits = 1 unit.	units	units
5 Have you smoked in the last 12 months? A smoker is anyone who has used any form of tobacco or nicotine replacement products in the last 12 months. If you answer No, we may carry out tests to check that you are a non-smoker.	○ No ○ Yes If Yes, please give details. cigarettes a day cigars a day pipes a day other	○ No ○ Yes If Yes, please give details. cigarettes a day cigars a day pipes a day other
How old were you when you started smoking?		

ONLY ANSWER THE FOLLOWING QUESTION IF YOU HAVE NOT SMOKED IN THE LAST 12 MONTHS

Question	Person 1	Person 2
Have you ever smoked any form of tobacco products?	○ No ○ Yes If Yes, please tell us how much you smoked a day. cigarettes a day cigars a day pipes a day other	○ No ○ Yes If Yes, please tell us how much you smoked a day. cigarettes a day cigars a day pipes a day other
How old were you when you started smoking?		
When did you stop smoking?	/ /	/ /
6 Have you ever been given medical advice to reduce your alcohol intake or had, or been advised to have, any form of treatment or counselling relating to your alcohol consumption?	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.

Section F – Your health

Please answer every question in this section.

	Person 1	Person 2
1 Before the age of 60, have any of your parents, brothers or sisters had: **Alzheimer's disease** **Cancer** **Diabetes** **Haemochromatosis** **Heart disease** (including cardiomyopathy, heart attack, angina or chest pain) **Huntington's disease** **Motor neurone disease** **Multiple sclerosis** **Muscular dystrophy** **Parkinson's disease** **Polycystic kidney disease** **Stroke** **Or any hereditary disorder?** If you need more space for your answer, please use page 33.	○ **No** ○ **Yes** If Yes, please give details. **relation** (e.g. father) **age** (when diagnosed) **condition** (if cancer, please tell us the type, e.g. bowel cancer) **relation** (e.g. father) **age** (when diagnosed) **condition** (if cancer, please tell us the type, e.g. bowel cancer)	○ **No** ○ **Yes** If Yes, please give details. **relation** (e.g. father) **age** (when diagnosed) **condition** (if cancer, please tell us the type, e.g. bowel cancer) **relation** (e.g. father) **age** (when diagnosed) **condition** (if cancer, please tell us the type, e.g. bowel cancer)
2 Have you ever used illegal or recreational drugs or injected non-prescription drugs? e.g. cocaine, heroin, cannabis, ecstasy.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
3 Have you ever tested positive, or are you awaiting test results for, Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome or Hepatitis B or C? If the result is negative, the fact you had an HIV test will not itself have any effect on your acceptance terms for insurance.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
4 In the last 5 years have you had any exposure to the risk of Human Immunodeficiency Virus infection? This can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
5 In the last 5 years have you tested positive or been treated for any disease which was transmitted sexually?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.

Section F continued

For questions 6 to 15, do you have, or have you ever had, any of the following?	Person 1		Person 2	
6 Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
7 Any neurological complaint, numbness, dizziness, involuntary shaking, loss of feeling, tingling of limbs or face, or temporary loss of muscle power or co-ordination	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
8 Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or any malignant condition	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
9 Irregular heartbeat, palpitations, heart murmur or heart disease including angina, heart attack or chest pains	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
10 Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
11 Diabetes or sugar in the urine	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
12 Any nervous or mental disorders e.g. anxiety, stress, depression, schizophrenia, suicide attempt.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
13 Any hereditary disorder	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
14 Any disorder of the eyes, or blurred or double vision, not fully corrected by glasses or contact lenses e.g. glaucoma, optic neuritis.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
15 Only answer this question if you are male **Any prostate enlargement or abnormal PSA (Prostate specific antigen), testicular or urinary problems** e.g. undescended testicle, difficulty or urgency in passing urine.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)

Section F continued

For questions 16 to 27, in the last 5 years have you had any of the following?	Person 1		Person 2	
16 Any cyst, growth, lump or swelling	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
17 Any mole or freckle that has changed in colour or appearance, bled, become painful or itchy, or increased in size	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
18 Bronchitis, pneumonia, emphysema or other lung disorder other than asthma.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
19 Any disorder of the digestive system, gall bladder, stomach, bowel or liver e.g. gastric ulcer, duodenal ulcer, hepatitis, jaundice, colitis, Crohn's disease, hernia, irritable bowel syndrome.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
20 A thyroid disorder	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
21 Any disorder of the kidneys or bladder e.g. blood or protein in urine or multiple urinary infections.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
22 Any fit or blackout	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
23 Any disorder of the muscles, bones, joints or limbs e.g. arthritis, rheumatoid arthritis, gout.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
24 Any disorder of the back or neck e.g. slipped disc.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
25 Any disorder of the skin or ears	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)
26 Any disorder of the blood e.g. anaemia.	○ **No**	○ **Yes** (If Yes, please also complete section G.)	○ **No**	○ **Yes** (If Yes, please also complete section G.)

Section F continued

Question	Person 1	Person 2
27 Only answer this question if you are female **Any biopsy or ultrasound of the breast, uterus, cervix or ovary, or any abnormal cervical smear or mammogram** You do not need to tell us about testing as result of pregnancy.	○ **No** ○ **Yes** (If Yes, please also complete section G.)	○ **No** ○ **Yes** (If Yes, please also complete section G.)
28 Are you currently certified by a doctor as unfit for work?	○ **No** ○ **Yes** (If Yes, please also complete section G.)	○ **No** ○ **Yes** (If Yes, please also complete section G.)
29 Are you currently experiencing any symptoms or complaints for which you have not consulted a doctor?	○ **No** ○ **Yes** (If Yes, please also complete section G.)	○ **No** ○ **Yes** (If Yes, please also complete section G.)
30 Are you currently awaiting, or been advised to seek, any medical or surgical consultation or follow-up?	○ **No** ○ **Yes** (If Yes, please also complete section G.)	○ **No** ○ **Yes** (If Yes, please also complete section G.)
31 In the last 5 years, other than those conditions you have already told us about in this application, have you: **– attended any other medical appointment** **– taken any other test or medication, or** **– received any other treatment?** Tick Yes even if you are awaiting the result of any test or currently receiving any treatment.	○ **No** ○ **Yes** (If Yes, please also complete section G.)	○ **No** ○ **Yes** (If Yes, please also complete section G.)

You do not need to tell us about any of the following treatments and confirmed conditions: acne, athlete's foot, blisters, cold sores, common colds, conjunctivitis, contraception, ear wax or syringing, food poisoning, hay fever, indigestion, infected or extracted wisdom teeth, infertility treatment, influenza, ingrowing toenails, miscarriage, pregnancy, shingles, sinus trouble, tonsillitis, vaccinations or vasectomy.

Question	Person 1	Person 2
32 Asthma **In the last 2 years, have you had asthma?**	○ **No** (If No, please go to question F40.) ○ **Yes** (If Yes, please complete questions F33 to F39 below.)	○ **No** (If No, please go to question F40.) ○ **Yes** (If Yes, please complete questions F33 to F39 below.)
33 How often do you have symptoms of asthma? e.g. shortness of breath, cough, chest tightness, wheezing.	○ **No longer have any symptoms** ○ **Once or twice a month** ○ **Daily** ○ **Continuous symptoms** ○ **Other** If Other, please give details.	○ **No longer have any symptoms** ○ **Once or twice a month** ○ **Daily** ○ **Continuous symptoms** ○ **Other** If Other, please give details.
34 How many asthma attacks have you had in the last 2 years? Do not include symptoms of mild chest tightness or breathlessness that resolve within half an hour of taking a reliever inhaler.	Please give details.	Please give details.

Section F continued

	Person 1	Person 2
35 In the last 2 years have you had to take steroids to treat your asthma, other than through an inhaler?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
36 Since reaching adulthood, have you ever been admitted to an Intensive Care Unit (ICU), or required the use of a mechanical ventilator due to your asthma? A mechanical ventilator is a machine with a tube that is passed into the lungs to assist with breathing.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
37 In the last 5 years have you been admitted to hospital due to your asthma?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
38 Does your occupational environment cause or exacerbate your asthma? e.g. exposure to gases, dust, chemicals, animals, high degree of physical exertion.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
39 In the last 2 years, how many days have you taken off work, or been unable to perform your normal daily activities, because of asthma?	**days**	**days**
40 Blood pressure **In the last 5 years, have you had any treatment for raised blood pressure, been advised to take treatment, or been advised to have your blood pressure monitored?**	○ **No** (If No, please go to question F48.) ○ **Yes** (If Yes, please complete questions F41 to F47 below.)	○ **No** (If No, please go to question F48.) ○ **Yes** (If Yes, please complete questions F41 to F47 below.)
41 When did you first find out that you had raised blood pressure?		
42 When did you last have your blood pressure read by a medical practitioner?		
43 Is more than 1 drug used to control your blood pressure?	○ **No** ○ **Yes**	○ **No** ○ **Yes**

Section F continued

	Person 1	Person 2
44 Do you know what your last blood pressure reading was?	○ **No** (If No, please answer (i) and (ii).) ○ **Yes** (If Yes, please answer (iii) below.)	○ **No** (If No, please answer (i) and (ii).) ○ **Yes** (If Yes, please answer (iii) below.)
i: In the last year, have all the medical practitioners treating your raised blood pressure, confirmed that all your blood pressure readings have been normal?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
ii: In the last year, have any of the medical practitioners treating your raised blood pressure: **– changed your medication or treatment?** **or** **– increased the dosage of your medication or treatment?**	○ **No** ○ **Yes**	○ **No** ○ **Yes**
iii: Please tell us your last reading:	**Systolic** The first number in the reading, e.g. '150' in a reading of 150/95. **Diastolic** The second number in the reading, e.g. '95' in a reading of 150/95.	**Systolic** The first number in the reading, e.g. '150' in a reading of 150/95. **Diastolic** The second number in the reading, e.g. '95' in a reading of 150/95.
45 Have you ever stopped treatment without your doctor's approval?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
46 Have you had, or do you expect to have, any hospital referrals for raised blood pressure?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
47 Have you had any complications or side effects as a result of raised blood pressure? e.g. dizziness, headaches, circulatory problems, chest pains.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
48 Cholesterol **In the last 5 years, have you had any treatment for raised cholesterol levels, been advised to take treatment or been advised to have your cholesterol levels monitored?** Treatment includes being advised to follow a low fat diet.	○ **No** (If No, please go to section G.) ○ **Yes** (If Yes, please complete questions F49 to F56 below.)	○ **No** (If No, please go to section G.) ○ **Yes** (If Yes, please complete questions F49 to F56 below.)
49 When did you first find out that your cholesterol levels were raised?		

Section F continued

	Person 1	Person 2
50 When did you last have your cholesterol read by a medical practitioner?		
51 Do you know what your last cholesterol reading was?	○ **No** (If No, please answer (i) and (ii).) ○ **Yes** (If Yes, please answer (iii) below.)	○ **No** (If No, please answer (i) and (ii).) ○ **Yes** (If Yes, please answer (iii) below.)
i: In the last year, have all the medical practitioners treating your raised cholesterol, confirmed that all your cholesterol readings have been normal?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
ii: In the last year, have any of the medical practitioners treating your raised cholesterol: **– changed your medication or treatment?** **or** **– increased the dosage of your medication or treatment?**	○ **No** ○ **Yes**	○ **No** ○ **Yes**
iii: Please tell us your last reading:	**Total cholesterol** **HDL cholesterol** (High Density Lipoprotein) Leave blank if HDL is unknown.	**Total cholesterol** **HDL cholesterol** (High Density Lipoprotein) Leave blank if HDL is unknown.
52 Are you still taking treatment for raised cholesterol levels?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
53 Is more than 1 drug used to control your cholesterol levels?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
54 Have you ever stopped treatment without your doctor's approval?	○ **No** ○ **Yes**	○ **No** ○ **Yes**
55 Have you had, or do you expect to have, any hospital referrals for raised cholesterol?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
56 Have you had any complications or side effects as a result of raised cholesterol? e.g. circulatory problems, chest pains.	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.

Section G – Additional health questions Condition 1

If you have ticked Yes to any of questions 6 to 31 in Section F, please also answer these questions.

If you do not give us the information we ask for in these questions or we need any further information, we may send you an additional questionnaire to complete.

	Person 1 – Condition 1	Person 2 – Condition 1
1 Number of question to which the following answers apply.		
2 What is the name of the medical condition or injury that you have had or currently have?		
3 When did your symptoms start? Please give a date.		
4 How often do you have symptoms?	○ **Daily** ○ **Weekly** ○ **Monthly** ○ **Once or twice a year** ○ **No longer have symptoms**	○ **Daily** ○ **Weekly** ○ **Monthly** ○ **Once or twice a year** ○ **No longer have symptoms**
5 If the symptoms have stopped, when was the last time you had symptoms of this condition? Please give a date.		
6 Have you had any surgery, investigations or tests for this condition?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
7 Do you expect or have you been advised to have surgery, tests or investigations, including any hospital referrals, for this condition?	○ **No** ○ **Yes** If Yes, please give details.	○ **No** ○ **Yes** If Yes, please give details.
8 What was the treatment prescribed?		
9 Is it still continuing?	○ **No** ○ **Yes**	○ **No** ○ **Yes**

Section G continued

If you have ticked Yes to any of questions 6 to 31 in Section F, please also answer these questions.

	Person 1 – Condition 1	Person 2 – Condition 1
10 How many days have you been off work because of this condition?	days	days
11 Which of the following best describes the severity of your condition?	○ Fully recovered with no remaining disability ○ Ongoing condition with no restrictions of daily activities or mobility ○ Mild symptoms with infrequent restriction of daily activities or mobility ○ Severe symptoms with infrequent restriction of daily activities or mobility ○ Daily activities and tasks significantly restricted	○ Fully recovered with no remaining disability ○ Ongoing condition with no restrictions of daily activities or mobility ○ Mild symptoms with infrequent restriction of daily activities or mobility ○ Severe symptoms with infrequent restriction of daily activities or mobility ○ Daily activities and tasks significantly restricted

Section G – Additional health questions Condition 2

If you have ticked Yes to any of questions 6 to 31 in Section F, please also answer these questions.

If you do not give us the information we ask for in these questions or we need any further information, we may send you an additional questionnaire to complete.

	Person 1 – Condition 2	Person 2 – Condition 2
1 Number of question to which the following answers apply.		
2 What is the name of the medical condition or injury that you have had or currently have?		
3 When did your symptoms start? Please give a date.		
4 How often do you have symptoms?	○ Daily ○ Weekly ○ Monthly ○ Once or twice a year ○ No longer have symptoms	○ Daily ○ Weekly ○ Monthly ○ Once or twice a year ○ No longer have symptoms
5 If the symptoms have stopped, when was the last time you had symptoms of this condition? Please give a date.		
6 Have you had any surgery, investigations or tests for this condition?	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.

Section G continued

If you have ticked Yes to any of questions 6 to 31 in Section F, please also answer these questions.

	Person 1 – Condition 2	Person 2 – Condition 2
7 Do you expect or have you been advised to have surgery, tests or investigations, including any hospital referrals, for this condition?	○ No ○ Yes If Yes, please give details.	○ No ○ Yes If Yes, please give details.
8 What was the treatment prescribed?		
9 Is it still continuing?	○ No ○ Yes	○ No ○ Yes
10 How many days have you been off work because of this condition?	days	days
11 Which of the following best describes the severity of your condition?	○ Fully recovered with no remaining disability ○ Ongoing condition with no restrictions of daily activities or mobility ○ Mild symptoms with infrequent restriction of daily activities or mobility ○ Severe symptoms with infrequent restriction of daily activities or mobility ○ Daily activities and tasks significantly restricted	○ Fully recovered with no remaining disability ○ Ongoing condition with no restrictions of daily activities or mobility ○ Mild symptoms with infrequent restriction of daily activities or mobility ○ Severe symptoms with infrequent restriction of daily activities or mobility ○ Daily activities and tasks significantly restricted

Section H – Financial information

Please complete this section if the application is:

- to protect a loan
- to cover Income Cover for Sickness
- to cover Key Person Income Cover for Sickness

Please answer questions 1 to 4 if the cover you are applying for is in connection with a loan.

	Plan owner
1 What is the name of the lender?	
2 What is the amount of the loan?	
3 What is the term of the loan?	
4 If the term and amount of cover of the plan are different to the term and amount of the loan, please provide full details of why this plan is required.	

Please complete either question 5 or 6 if you are applying for Income Cover for Sickness.
Do not answer questions 5 or 6 if you are applying for Key Person Income Cover for Sickness.

Please answer question 5 if you are employed.

	Person 1			Person 2		
5 What were your earnings for the last 3 years?	**Current year £**	**Last year £**	**Previous year £**	**Current year £**	**Last year £**	**Previous year £**
Salary						
Dividends						
Regular commission						
P11D benefits						
Profit share						
Total						

Please answer question 6 if you are self-employed.

6 What were your net taxable earnings (after allowable deductions/expenses) for the last 3 years?	**Current year £**	**Last year £**	**Previous year £**	**Current year £**	**Last year £**	**Previous year £**
How long has the business been established?						

Section H continued

Please complete questions 7 to 20 if you are applying for Key Person Income Cover for Sickness.

For us to fully consider an application for Key Person Income Cover for Sickness, it is important that you provide as much financial information as possible when completing the following questions. The information should be obtained from the person covered or the company accountant or secretary, and must be signed by the company accountant or secretary.

If you need more space, please use page 33.

	Plan owner		
7 What is the name of the business?			
8 What is the nature of this business?			
9 Please tell us how long this business has been operating.	**years**	**months**	
10 What proportion of the business does the person covered own?	**%**		
11 How many people does the business employ?			
12 Please tell us how long the person covered has been in service with the business.	**years**	**months**	
13 Is the business applying for key person income protection on any other key people, or is there another key person income protection in place on any other key people?	○ **No**	○ **Yes**	
If Yes, please give full details opposite.			
name			
position			
amount of benefit (£)			
who plan is held with			
if No, please give full details why not.			
14 Please provide trading figures for the business over the last 3 years.			
year			
turnover			
gross profit*			
net profit*			

*if a gross or net loss is shown, please enclose copies of the last 2 years' reports and accounts.

Section H continued

	Person 1	Person 2
15 Please tell us what the person covered's salary or emoluments have been in the last 3 years.	current year last year previous year	current year last year previous year
16 Please give us full details of the person covered's occupation. This should include full details of their skills, duties and responsibilities.		
17 Please tell us why the person covered is deemed to be key to the business, and how the level of cover has been calculated.		
18 How much of the gross profit of the business is fairly attributed to the person covered?	%	%
19 Please tell us how the payment period has been determined.		
20 Please tell us how the deferred period has been determined.		

Declaration

Only sign here if you have completed Section H.

I/We declare that:

- the answers above are true to the best of my knowledge
- I have not witheld any information that may influence the assessment or acceptance of this application.

I agree that:

- this questionnaire will form part of the application to Bright Grey
- the contract may be invalidated if I do not disclose any important information that is known to me.

Full name of company accountant or secretary	
Signature	
Title/Position	

The plan owner and person covered must always sign the declaration on page 29.

Section I – Your GP

	Person 1	Person 2
1 Your GP If you need to check the GP's address details, please go to **www.click-for-health.com**. If you do not give us their full name and address, it could delay your application. We may not always contact your GP to ask for more medical information so please make sure you give us all of the information we ask for when filling in your application.	**GP name** **surgery name** **surgery address** **postcode** **phone** **fax** **email**	**GP name** **surgery name** **surgery address** **postcode** **phone** **fax** **email**
2 Have you been with this GP for less than 6 months?	○ **No** ○ **Yes** If Yes, please give us your previous GP's name and address. **GP name** **surgery name** **surgery address** **postcode**	○ **No** ○ **Yes** If Yes, please give us your previous GP's name and address. **GP name** **surgery name** **surgery address** **postcode**

Section J – How we use your personal information, access to medical reports information and declaration and consent

This section is made up of 3 parts:	1 How we use your personal information 2 Access to medical reports information 3 Declaration and consent
The person covered should	**read** sections **1**, **2** and **3**, **tick** the box in section **3** if they want to see their medical report, and **sign** section **3**.

1. How we use your personal information (please read)

We, The Royal London Group (including Bright Grey), may obtain personal information either from you directly, or with your consent, from your approved intermediary or from other sources such as your doctor or an identity authentication agency.

We will use your personal information (including sensitive personal information) for the following purposes:

- Providing and developing our products and services
- Improving customer care
- Verifying your identity and fraud prevention
- Research and analysis
- Marketing
- Legal and regulatory reasons
- Administering your plan.

We will retain your personal information for a reasonable period and we may also share information about you with other companies within the Royal London Group, your approved intermediary, our service providers and agents and with third parties such as auditors, underwriters, reinsurers, medical agencies, identity authentication and fraud prevention agencies, other financial institutions and legal and regulatory bodies.

Your personal data may be processed in countries outside the European Economic Area. This processing will be carried out by experienced and reputable organisations and only on terms which safeguard the security of your data and comply with the requirements of the Data Protection Act 1998.

We may contact you by mail, phone, fax, email or other electronic messaging either directly or through your approved intermediary with further offers, promotions and information about our products and services that may be of interest to you. By providing us with this information you consent to being contacted by these methods for these purposes. Please tick this box if you do not wish to receive these communications.

○ Person 1 ○ Person 2

○ Other applicant

We may also share your information with carefully selected third parties, who may contact you by mail, phone, fax or electronic messaging to let you know about products and services which they believe may be of interest to you. By providing us with this information you consent to being contacted by these methods for these purposes.

Please tick this box if you do not wish to receive such information.

○ Person 1 ○ Person 2

○ Other applicant

We may carry out an identity authentication check to verify your identity. This involves checking the details you supply against those held on any databases that may be accessed by the reputable third party company which carries out our checks. This includes information from the Electoral Register and fraud prevention agencies.

We will use scoring methods to verify your identity. A record of this search will be kept and may be used to help other companies verify your identity.

We may also pass information to financial and other organisations involved in money laundering and fraud prevention to protect ourselves and our customers from theft and fraud. If you give us false or inaccurate information and we suspect fraud, we will record this and share this information with other organisations.

We may monitor and record phone calls and retain these for the purposes of training and quality assurance and to ensure that we have an accurate record of your instructions.

If you provide us with information about another person, you confirm that they have appointed you to act for them to consent to the processing of their personal data and that you have informed them of our identity and the purposes (as set out above) for which their personal data (including sensitive personal data) will be processed.

You have the right to ask for a copy of the information that we hold on you, for which we are entitled to charge a small fee. You can ask us to correct any inaccuracies in your information.

If you have any questions about how we will use your personal information or if you would like to receive our marketing communications by some but not all of the above methods, please contact a member of the Bright Grey Customer Care Team on 0845 6094 500.

2. Access to medical reports information (please read)

We may need to obtain a medical report from your current GP or specialist, or from a doctor you have seen in the past.

You have specific rights in relation to medical reports, which are covered in the Access to Medical Reports Act 1988 (also the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, and the Access to Health Records and Reports Act 1993 (Isle of Man)).

Before we ask for such a report, we need your consent, which you can give by signing the declaration in section **3**. You can choose not to give your consent, but then we may not be able to continue with your application. This does not prevent you from applying to other insurance companies for insurance.

We will let you know if we ask for a report. Under the above Acts, you can choose to see your medical report before it is sent to us. You will then have 21 days to make arrangements with your doctor to see it.

You should indicate below whether you want to see your report. If you do not want to see the report now, you can still contact your doctor later and tell them that you do in fact want to see it. As long as it has not already been sent to us, you will still have 21 days from the time you contact your doctor to make arrangements to see it.

If the report has already been sent to us, you are entitled to see a copy of the report at any time during the 6 months following the date the report was 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 say that you do want to see the report, then it will not be sent to us until:

either you have seen the report

or 21 days have passed since we requested the report and the doctor has not heard from you.

If you see the report, you can withdraw your consent for the doctor showing it to us, or you can ask the doctor to change it if you disagree with it. If the doctor refuses to change it, you can insist that they attach a statement of your views to the report.

A doctor may refuse to let you see your report if they feel that seeing it will cause physical or mental harm to you or others.

Note: Your doctor is entitled to charge you for supplying you with a copy of the report.

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

Your current health:	• any care, medication or treatment you are currently receiving • the results of referrals or tests you are waiting for.
Time off work:	• any time off work in the last 3 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
	  • musculoskeletal disease or injury, e.g. arthritis, rheumatism, back problems or any other disorder of the joints or muscles
	  • anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
	  • suicidal thoughts or attempts at suicide
	  • conditions related to drug or alcohol misuse or smoking or chewing tobacco
	• details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last 2 years, urinalyses (tests on urine), X-rays or other investigations
	• any blood pressure readings in the last 3 years.

Family history of disease:	• 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 • 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 or your doctor provide about your health may result in us:	• setting payments at standard rates • increasing payments above standard rates • refusing to provide insurance.
If you have any questions about your rights under the act please contact:	Bright Grey, 2 Queen Street, Edinburgh EH2 1BG.

bright grey®

Protection. We make it personal

3. Declaration and consent (please read)

Bright Grey is a division of Royal London. The Royal London Group consists of The Royal London Mutual Insurance Society Limited and its subsidiaries.

By signing this declaration, I give Bright Grey permission:	• to ask for information from any insurance office to which an application has been made for insurance • to disclose my name, address, phone number and date of birth to an approved medical agency in order to arrange and obtain medical examinations and tests • to gather medical reports (which may include full medical records) within 6 months of the start of the plan or after my death, in relation to any claim made on the plan • to ask any doctor I have seen for information about anything which affects my physical or mental health, and I understand my rights under the Access to Medical Reports Act 1988 • to store and use information about me, including sensitive personal data such as health details, in the way described in section **1** How we use your personal information.

I agree that:	• if my health changes, or any other detail affecting the application changes, between the date of this application and the date Bright Grey assumes risk on the plan, I will inform Bright Grey in writing. I understand that Bright Grey will then have the right to reconsider terms if appropriate
	• if I have a financial adviser:
	  • they are authorised to give Bright Grey any information that is missing from my application form; and
	  • they are authorised to accept any amendment which Bright Grey proposes to make to my plan (including the acceptance of any non-standard terms) and to instruct Bright Grey to start my plan on my behalf, provided that:
	either the financial adviser has confirmed to Bright Grey that I have indicated my agreement to the amendment, instruction or inclusion of additional information
	or the amendment, instruction or inclusion of additional information shall not take effect until the financial adviser has confirmed to Bright Grey that I have indicated my agreement.

I understand that:	• I can request a copy of the plan details for the Business Protection Menu • this plan will be issued subject to the law of England and Wales • Bright Grey may request medical information within 6 months of the start of the plan to check the accuracy of any statement made in, or in connection with, this application. If the person covered does not give their consent to Bright Grey obtaining this information, or any statement is inaccurate and this affects Bright Grey's assessment of the insurance risk, Bright Grey will then have the right to reconsider or withdraw terms if appropriate and my plan may be cancelled • if I do not give Bright Grey all facts that are likely to influence the assessment and acceptance of this application form, any plan issued as the result of this application may be cancelled or the terms changed, and any claims may be refused.

3. Declaration and consent continued (please read)

I declare that:

- I have received a copy of the key facts of the Business Protection Menu
- if I have applied as a non-smoker that I have not used any form of tobacco or nicotine replacement products in the last 12 months
- the answers in this application form are true and complete, to the best of my knowledge and belief
- I have read the statement in section **2** notifying me of my rights under the Access to Medical Reports legislation, and consent to my doctor providing medical reports to Bright Grey, so that they can deal with my application for a protection plan.

Person 1 and Person 2 should always complete these boxes.

Please only tick this box if you DO want to see your medical report before it is sent to Bright Grey.

Person 1	Person 2
name	**name**
postcode	**postcode**
○ **Yes** I **DO** want to see my medical report. I understand that it will not be sent to Bright Grey until I have seen it, and that they will not be able to make a decision on my application until then.	○ **Yes** I **DO** want to see my medical report. I understand that it will not be sent to Bright Grey until I have seen it, and that they will not be able to make a decision on my application until then.

○ I/We did **NOT** receive advice from a financial adviser about buying this plan.

I agree that this application together with the Business Protection Menu plan quote, key facts and the plan details shall form the basis of the contract between me and Royal London, on behalf of Bright Grey.

Person 1	Person 2
signature	**signature**
date / /	**date** / /

If signing on behalf of a company or other corporate entity, please state your name and position.

Other applicant

signature

date / /

other applicant – print name

other applicant – position

Section K – Direct Debit details and starting your plan

When you send us your application, we may be able to offer you Instant Cover. This means that we may cover you while we process your application. You can find full details of when we offer Instant Cover in our key facts of the Business Protection Menu plan. We cannot offer you Instant Cover unless we have a method of collecting payments when your plan starts. So please make sure you give us your bank details below.

1 Is the person paying for this plan the plan owner?

○ **No** – Please go to question **2**.

○ **Yes** – Please go to question **3**.

2 Please give us the name of the individual or business who will be paying for the plan.

Individual paying for the plan	Business paying for the plan
name	**name**
If an **individual** is paying for this plan, we may need to verify their identity. So that we can do this, please give us their home address and date of birth.	If a **business** is paying for this plan, we may need to ask for more detailed information when we receive your application.
address	**address**
postcode	**postcode**
date of birth / /	**type of business (e.g. partnership, plc etc.)**

3 Is more than one signature required to authorise payments?

○ **No** ○ **Yes**

If Yes, please make sure that every person whose signature is required to authorise payments signs the Direct Debit mandate.

4 How would you, or the person paying for this plan, like to pay?

Depending on the start date of your plan, the first payment may not be collected on the day you choose. We will write to you at least 10 working days before we collect the first payment.

○ **Monthly by Direct Debit**

We will take payments from your account on the same day of the month as the start date of your plan (e.g. 1st, 10th, etc).

If you would prefer to choose a different day of the month please tell us below.

date / / **(between 1st and 28th inclusive)**

○ **Yearly by Direct Debit**

bright grey®

Protection. We make it personal

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

DIRECT Debit

Name and full postal address of your Bank or Building Society

to: the manager Bank/Building Society

address

postcode

Name(s) of Account Holder(s)

Bank/Building Society account number

Branch sort code

Service user number

6	7	1	7	5	2

Reference

Instruction to your Bank or Building Society

Please pay Bright Grey Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this may remain with Bright Grey and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

date / /

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit Bright Grey will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Bright Grey 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 Bright Grey 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 Bright Grey asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

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Additional information

If you need more space for any answers please use this page and include the relevant question number. If you still need more space please use an additional sheet of paper. Remember to sign, date and attach it securely to the application.

Additional information continued

If you need more space for any answers please use this page and include the relevant question number. If you still need more space please use an additional sheet of paper. Remember to sign, date and attach it securely to the application.

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PC1149C.0711