

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. If you are not sure whether to include any information, then please include it.

The information you gave us on your original application form will still form part of your contract with Royal London, on behalf of Bright Grey. If any of the information has changed from your original application form you must tell us on this form.

This declaration of health form, together with your original application form, your quote and plan details will then form the basis of your proposed contract with Royal London, on behalf of Bright Grey.

If any of the information you give us on this form affects the application, Bright Grey will then have the right to reconsider or withdraw terms if appropriate.

Please contact our Customer Care Team if you need reminding of the information you put in your application form and would like us to send you a copy.

Please remember that you must tell us if your health changes, or any other detail affecting your application changes between you completing this form and sending it back to us, and your plan starting, restarting or changing. If you need more space for any information, please use the last page of this form.

1 About the people to be covered	Person 1	Person 2
1a: Your full name	<input type="text"/>	<input type="text"/>
1b: Date of birth	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
1c: Plan number (if known)	<input type="text"/>	<input type="text"/>
1d: Date of application (if applicable)	<input type="text" value="/ /"/>	<input type="text"/>
1e: Since you completed your original application form have you applied for any other cover with any other insurance company?	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <input type="text"/>
2 Your job, leisure activities and lifestyle	Person 1	Person 2
2a: Since you completed your original application form has there been any change to the country in which you are permanently resident?	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <input type="text"/>

Declaration of health

2 Your job, leisure activities and lifestyle	Person 1	Person 2
<p>2b: In the next 6 months, will you be moving from the country in which you are permanently resident?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>2c: Has there been any change in your job, or the activities involved in your job since you completed your original application form? e.g. you now work at heights, your job now involves hazardous duties or an increase in manual or driving work</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>2d: Have you become a member of the TA or Armed Forces reservists since you completed your original application form?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>2e: Since you completed your original application form have you taken up any hazardous leisure activities? e.g. aviation, caving or potholing, hang-gliding, motor sports, mountaineering or rock climbing, parachuting, underwater diving or yachting.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>2f: Has there been a change to your smoker status since you completed your original application form? A smoker is anyone who has used any form of tobacco or nicotine replacement products in the last 12 months.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>2g: Since you completed your original application form have you had exposure to the risk of HIV infection? This can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

Declaration of health

3 Your health	Person 1	Person 2
<p>3a: Since you completed your original application form, has your weight increased or decreased by 7lbs (3kgs) or more, for reasons other than stopping smoking, pregnancy or dieting?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>3b: Since you completed your original application form:</p> <p>I. have you become certified by a doctor as unfit for work?</p> <p>II. are you experiencing any symptoms or complaints for which you have not consulted a doctor?</p> <p>III. are you awaiting, or been advised to seek, any medical or surgical consultation or follow-up?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>3c: Since you completed your original application form have you:</p> <ul style="list-style-type: none"> attended any medical appointment taken any test or medication, or received any other treatment? <p>Tick Yes even if you are awaiting the result of any test or currently receiving any treatment.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes Please give full details <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

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, haemorrhoids, hay fever, indigestion, infected or extracted wisdom teeth, infertility treatment, influenza, ingrowing toenails, miscarriage, shingles, sinus trouble, tonsillitis, uncomplicated fractures, uncomplicated pregnancy, vaccinations or vasectomy.

