

GUARANTEED PERSONAL PROTECTION PLAN APPLICATION

SINGLE OR FIRST JOINT APPLICANT	SECOND APPLICANT (FOR JOINT PLANS)
Title (Mr/Mrs/Ms/Miss/Other)	Title (Mr/Mrs/Ms/Miss/Other)
Surname	Surname
Forenames	Forenames
Address	Address
Postcode	Postcode
Mobile No.	Mobile No.
Tel No. <i>For your information please see Data Protection Notice</i>	Tel No. <i>For your information please see Data Protection Notice</i>
Email Id	Email Id
Date of birth <i>(you must be between the ages of 18 and 69)</i>	Date of birth <i>(you must be between the ages of 18 and 69)</i>
Please Tick <input type="checkbox"/> Male <input type="checkbox"/> Female	Please Tick <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status	Marital Status
Occupation	Occupation

LICI UK - GUARANTEED PERSONAL PROTECTION PLAN APPLICATION

<p>Do you already hold any policies with LICI ?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please state policy number(s)</p> <p>.....</p>	<p>Do you already hold any policies with LICI ?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please state policy number(s)</p> <p>.....</p>
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GUARANTEED LIFETIME PROTECTION PLAN DETAILS		
Contribution and frequency	Monthly £ (min £20)	Yearly £ (min £240)
Or guaranteed cash amount £		
.....		
If electing for a joint plan please advise whether 1st or 2nd death		
.....		
Term of Plan years (min 10 years, max 36 years and max age at maturity 75 years)	
Accident Benefit (please tick)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

GUARANTEED PERSONAL PROTECTION PLAN DETAILS		
Please Tick	<input type="checkbox"/> Level Term or <input type="checkbox"/> Decreasing Term	
Contribution and frequency	Monthly £ (min £5)	Yearly £ (min £60)
Or Guaranteed Cash Amount (Initial guaranteed cash amount if decreasing term) £		
.....		
Term of Plan years (min 5 years, max 40 years and max age at maturity 74 years)	
Income option (required)	<input type="checkbox"/> (please tick this box if you wish to elect that the lump sum on death is paid in instalments)	

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SINGLE OR FIRST JOINT APPLICANT

Note1: Please complete the following questions in full and provide any further details in the supplementary questionnaire.

Note2: See overleaf for our policy on genetics.

1	Are you receiving or waiting to receive any form of medical advice or treatment including tablets, diet, medicines, inhalers or injections, whether prescribed or not, for any medical or psychiatric condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Do you suffer from or have you ever suffered from any of the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	a. Heart attack, stroke or transient ischaemic attacks, angina, heart murmur, rheumatic fever, or other heart abnormality, disease or impairment of the arteries or veins, raised cholesterol, or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Diabetes, or any disease or impairment of the stomach, bowel, bladder, kidneys, pancreas, or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Arthritis, gout or any form of spinal problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Any form of nervous or mental disorder, or have you required tranquillisers or antidepressants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Cancer, any other tumour, lump, or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Asthma, bronchitis, emphysema, or any other disorder affecting the lungs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. Multiple sclerosis, paralysis, numbness or tingling, visual disturbance, Parkinson's disease, epilepsy, fits, any disorder of the brain, any condition affecting the nervous system or any hereditary disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h. Any illness lasting or requiring treatment for 28 days or more, excluding any details already given above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have any of your parents, brothers, or sisters, died from or suffered from, before the age of 65 years, heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, multiple sclerosis, paralysis, or any hereditary disorder? If yes, please advise which condition and give their age when they first suffered from the condition.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you smoked tobacco in the last 12 months? If yes, please advise type and average daily consumption.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cigarettes Cigars Pipe	

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5	<p>Do you drink alcohol? If yes, please advise your average weekly consumption in units of alcohol (One unit = one standard glass of wine, one measure of spirits, or half a pint of beer)</p> <p>Average weekly consumption Units</p> <p>.....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
6	<p>Please state your height and your weight</p>	<p>..... Height</p> <p>..... Weight</p>
7	<p>Have you tested positive for HIV/AIDS or Hepatitis B or C, or have you been tested or treated for other sexually transmitted diseases or are you awaiting the results of such a test?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
8	<p>Do you belong to, or have you ever belonged to, or been a sexual partner of any of the following currently recognised AIDS risk groups: homosexual, bisexual, intravenous drug user, haemophiliac or recipient of blood or blood products outside of the UK or a sexual partner of anyone who is or has been HIV positive?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If you have answered yes to questions 7 and/or 8, for confidentiality details may be submitted in a sealed envelope addressed to the Chief Medical Officer, LICI, 10th Floor, York House, Empire Way, Wembley, HA9 0PX and attached to this application.</p>		
9	<p>Do you, or have you any intention of participating in private aviation or in any hazardous sports?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If yes, please give further details</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>		
10	<p>Do you intend to live or work or travel abroad other than for holidays, or You have done so in the last 5 years?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
11	<p>Has any application for life insurance, critical illness or health insurance on your life ever been declined, postponed or accepted at an increased premium or on special terms?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If yes, please advise the reason and date</p> <p>.....</p> <p>.....</p>		

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12	Please give details of the doctor who holds your medical records	
	Name/Dr	
	Address	
	
	
	
Postcode		
.....		
Telephone number		
.....		

SECOND APPLICANT (FOR JOINT PLANS)		
<i>Note1: Please complete the following questions in full and provide any further details in the supplementary questionnaire.</i>		
<i>Note2: See overleaf for our policy on genetics.</i>		
1	Are you receiving or waiting to receive any form of medical advice or treatment including tablets, diet, medicines, inhalers or injections, whether prescribed or not, for any medical or psychiatric condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Do you suffer from or have you ever suffered from any of the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	i. Heart attack, stroke or transient ischaemic attacks, angina, heart murmur, rheumatic fever, or other heart abnormality, disease or impairment of the arteries or veins, raised cholesterol, or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	j. Diabetes, or any disease or impairment of the stomach, bowel, bladder, kidneys, pancreas, or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	k. Arthritis, gout or any form of spinal problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	l. Any form of nervous or mental disorder, or have you required tranquillisers or antidepressants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	m. Cancer, any other tumour, lump, or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	n. Asthma, bronchitis, emphysema, or any other disorder affecting the lungs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	o. Multiple sclerosis, paralysis, numbness or tingling, visual disturbance, Parkinson's disease, epilepsy, fits, any disorder of the brain, any condition affecting the nervous system or any hereditary disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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	p. Any illness lasting or requiring treatment for 28 days or more, excluding any details already given above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have any of your parents, brothers, or sisters, died from or suffered from, before the age of 65 years, heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, multiple sclerosis, paralysis, or any hereditary disorder? If yes, please advise which condition and give their age when they first suffered from the condition.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you smoked tobacco in the last 12 months? If yes, please advise type and average daily consumption. Cigarettes Cigars Pipe	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Do you drink alcohol? If yes, please advise your average weekly consumption in units of alcohol (One unit = one standard glass of wine, one measure of spirits, or half a pint of beer) Average weekly consumption Units	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Please state your height and your weight Height Weight
7	Have you tested positive for HIV/AIDS or Hepatitis B or C, or have you been tested or treated for other sexually transmitted diseases or are you awaiting the results of such a test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Do you belong to, or have you ever belonged to, or been a sexual partner of any of the following currently recognised AIDS risk groups: homosexual, bisexual, intravenous drug user, haemophiliac or recipient of blood or blood products outside of the UK or a sexual partner of anyone who is or has been HIV positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If you have answered yes to questions 7 and/or 8, for confidentiality details may be submitted in a sealed envelope addressed to the Chief Medical Officer, LICI, 10th Floor, York House, Empire Way, Wembley, HA9 0PX and attached to this application.	
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	If yes, please give further details	

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10	Do you intend to live or work or travel abroad other than for holidays, or You have done so in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Has any application for life insurance, critical illness or health insurance on your life ever been declined, postponed or accepted at an increased premium or on special terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please advise the reason and date	
12	Please give details of the doctor who holds your medical records Name/Dr Address Postcode Telephone number	

<p>SUPPLEMENTARY QUESTIONNAIRE</p> <p><i>If you have answered yes to any of the above questions please give further details by completing the form below. If there is insufficient room please use a blank sheet of paper for any further details, ensuring that you also add your full name and address.</i></p>	
<p>1st or only Life Assured</p>	<p>2nd Life Assured (Joint Life only)</p>
<p>Name of condition</p>	<p>Name of condition</p>
<p>Date of first symptoms</p>	<p>Date of first symptoms</p>

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<p>Description of symptoms</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>Description of symptoms</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>Is the condition or symptoms ongoing?</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>Is the condition or symptoms ongoing?</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>What medication are you taking, if any?</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>What medication are you taking, if any?</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>What investigations have been carried out and what were the results?</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>What investigations have been carried out and what were the results?</p> <p>.....</p> <p>.....</p> <p>.....</p>

DECLARATION AND CONSENT

IMPORTANT

Before signing the declaration please ensure that you have read and understood your rights regarding access to your medical records as explained overleaf and note that failure to disclose all material facts may influence the assessment and acceptance of your application or constitute grounds for the rejection of a claim. If in doubt, the facts should be disclosed.

I hereby apply to LICI for the above contract on my life and declare that all answers given are, to the best of my knowledge and belief, true and complete, and that I have not withheld any material information that may influence the assessment or acceptance of this application. I understand that failure to do so may invalidate any future claim.

I agree that all statements made by me in connection with this application shall form the basis of the contract between myself and LICI.

I agree to inform LICI immediately if there is any change in my health or personal circumstances before commencement of the contract.

I consent to LICI seeking medical information from any doctor who has at any time attended me concerning anything which affects my physical or mental health, or seeking medical information from any insurance company to which an application has been made on my life and I authorise the giving of such information.

I have been informed of my statutory rights under The Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, as explained overleaf, and I agree that a copy of this consent shall have the same validity as the original.

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I do not * wish to see the medical report before it is sent to LICI

SECOND APPLICANT (JOINT LIFE ONLY)

I do not * wish to see the medical report before it is sent to LICI

* If you wish to see your medical report before it is sent to LICI please delete the word 'not'

SIGNATURE SINGLE OR FIRST JOINT APPLICANT	SIGNATURE SECOND APPLICANT (joint life only)
..... Date Date

A copy of the policy conditions and/or application form is available on request

Access to Medical Reports Act 1988, Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

RIGHTS AND PROCEDURES

We need your consent before we can approach any doctor for a medical report about you. This is given by signing the declaration. Before you sign, you should read this section carefully. It details your rights under the Act.

You do not have to give your consent. If you do not give your consent we may be unable to proceed with your application.

You can request to see the report before it is sent to us. We will inform the doctor that you want to see the report before it is sent to us and confirm your request to you in writing. You will then have 21 days to arrange with the doctor to see the report.

If you haven't arranged to see the report within this period the doctor will send it to us. The doctor may charge you a reasonable fee if you ask to see a copy of the report.

If you indicate that you don't want to see the report, we don't have to tell you if we apply for one. You can, however, ask to see a copy of the report within 6 months of it being sent to us.

If you have seen the report before it is sent to us, the doctor will require your written consent to send it to us. You have the right to ask the doctor to change anything that you consider to be incorrect or misleading. The doctor can however refuse to make any alterations. If the doctor refuses to change the report you may attach a note giving your views.

The doctor can refuse to let you see all or part of the report if, in their opinion, it is likely to :

- Adversely affect your physical or mental health or that of others
- Indicate the doctor's intentions to you
- Reveal the identity of a third party who has given information about you unless they have consented to it's disclosure or it has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you. You will only be able to see the remaining part of the report. If the whole report is affected the doctor will advise you and not send it to us without your written consent. If you refuse to give your consent we may be unable to proceed with your application.

STATEMENT ON GENETICS

In accordance with the Association of British Insurer's (ABI) policy on genetics and insurance, you do not need to tell us about any genetic test result you have had if this application for insurance, taken together with any other insurance policies you already have for this type of insurance, totals to £500,000 or less.

Above this limit you may need to tell us about certain genetic test results where the Government's Genetics and Insurance Committee (GAIC) has approved them for insurers to use.

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If you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at www.abi.org.uk/consumer2/disclosure.htm. However you must tell us if you either have a family history of, are experiencing symptoms of, or are having treatment for a medical condition including any genetically inherited condition.

If you wish to disclose to us a negative genetic test result, which shows that you have not inherited a genetic disorder, we will take this into account in setting your premium, providing your clinical geneticist confirms that the test result indicates a reduced risk of developing the inherited disease.

DATA PROTECTION NOTICE

The Life Insurance Corporation of India may use the information supplied on this form, or during any future communication, for the purpose of administering your policy, or holding, for research and analysis purposes and as part of our ongoing commitment to customer service. We may also contact you about further products or services that we think may be of interest to you. We may contact you by telephone, post, or electronic methods.

Any information you provide will be kept confidential and will only be disclosed if required for regulatory or legal purposes, or where you have given your consent, or to carefully selected third parties under contract to safeguard your confidentiality.

You can ask for a copy of the information we hold about you by writing to the Data Protection Officer, LICI, 10th Floor, York House, Empire Way, Wembley, Middlesex HA9 0PX subject to a fee.

If you would prefer not to receive information about our products and services, please tick here

FOR OFFICE USE ONLY
Adviser's name
Adviser's number
Other adviser's details for split commission purposes
% age commission split (if any)
IFA details
Introducer details
Lead source (e.g. Wembley generated, referral, self generated)

DIRECT DEBIT INSTRUCTION

Please fill in the whole form using a ball point pen:

Send to:

Life Insurance Corporation of India UK
York House,
Empire Way,
Wembley,
Middlesex HA9 0PX

Originator's Identification Number

6	7	9	3	6	4
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Bank/Building Society account number

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

Reference Number PLEASE LEAVE BLANK

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

Branch Sort Code

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

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

Please pay Life Insurance Corporation of India UK 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 Life Insurance Corporation of India UK 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

Address

.....
.....
.....

Name(s) of Account Holder(s)

.....
.....

Signature(s)

.....
.....

Postcode

.....

Date

.....

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

Direct Debit Guarantee

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amount to be paid or the payment dates change, The Life Insurance Corporation of India UK will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by The Life Insurance Corporation of India UK or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.
- This guarantee should be detached and retained by the Payer.

Verification of Identity - Money Laundering Checklist

	1st Applicant	2nd Applicant	Other Payee
Title			
Forename(s)			
Surname			
Home Address			
Date of Birth			

Address Check	1st Applicant	2nd Applicant	Other Payee
Type			
Verification Details			
- Name of the Utility Co. & Ref No			
- Name of the Council Tax & Ref No			
- Bank Statement Name of bank a/c s/c			

Identity Check	1st Applicant	2nd Applicant	Other Payee
Type			
Verification Details			
- Passport No Date Issued Expiry Date			
- Driving License Ref No			
- Benefit Book			

Advisor No		Authorisation MLRO Authority to proceed Date
Advisor Name		
Case Ref No		
Date		

I have checked the identity / address of the client/s shown above, and I can confirm, that the attached copy/ ies of the information provided reflect a true copy of the original/s which I have seen.

Signed LICI Financial Advisor.

LICI UK is a trading name of the Life Insurance Corporation of India which is registered in England and Wales, Company Number FC005008.
Office Address: York House, Empire Way, Wembley, Middlesex HA9 0PX. The Life Insurance Corporation of India is authorised and regulated by the Financial Services Authority.
We only provide information and advice on the Protection, Pension, Savings and Investment products and services from our own range and selected third party providers.