

For financial advisers only | Personal Protection

# Data capture form

Version number 09/11

## Key points

This *Data capture form* from AEGON (a brand name of Scottish Equitable plc) is split into two sections.

The information in section A allows you to get an illustration from our online services. Section B allows you to collect the further information we need to progress that online illustration to an online application.

You may have to contact your client(s) if we need additional underwriting information. If you don't have access to your client(s), the information you enter online will be automatically saved for 30 days so you can get in touch with your client(s).

You can download additional point of sale questionnaires from our website: [www.aegon.co.uk/adviser](http://www.aegon.co.uk/adviser). You can also get copies of all our trust literature from our website or by getting in touch with our customer service centre.

### Important contact details:

[www.aegon.co.uk/adviser](http://www.aegon.co.uk/adviser)  
Customer Service Centre:  
Email: [protect\\_support@aegon.co.uk](mailto:protect_support@aegon.co.uk)  
Telephone: 08456 00 14 02  
Fax: 08456 00 17 01  
Underwriting helpline: 08457 83 54 73

## Your checklist:

- I've given a copy of the Key features documentation to the client
- I've given the pull out page 'Your online application – what happens next?' (page 27) to the client

Please make sure you send in the following additional information (where necessary):

- Completed point of sale questionnaires (if not already entered into our online new business service)
- Additional personal information (if your client has chosen to write to our Chief Medical Officer separately)

Please make sure any documentation you send to us includes the online application reference number, which you can find at the top right-hand side of the online services new business screens.

Any additional information including the General practitioner's report consent declaration should be sent to:

AEGON  
Ballam Road  
Lytham St Annes  
Lancashire  
FY8 4JZ

## For financial adviser use only

For the purposes of Financial Services Authority reporting:

Did you give the applicant(s) advice about choosing to set up this policy?

- Yes  No

## Adviser reference

(Please give your adviser reference as it applies within your own organisation. Please don't put your client's(s') name(s) in this box.)

## Important notes for you

### Online services – service exclusions

Please note that our online service doesn't process cases where:

- the life/lives to be assured aren't prepared to submit bank information online
- the Direct Debit payments aren't being made from the life/lives to be assured's personal UK bank account
- the life/lives to be assured haven't been informed of how their personal data will be processed
- the 'source of funds' concession isn't being used for money laundering requirements
- the life/lives to be assured has/have more than one occupation
- there's no insurable interest
- the life/lives to be assured aren't the same as the applicant(s)
- the life/lives to be assured are resident outside England, Scotland, Wales or Northern Ireland
- the life/lives to be assured are resident in the Channel Islands or Isle of Man

### Money laundering

Our online service requires premiums to be paid from a UK bank account in the life/lives assured's(s') individual or joint names. Where this is the case, we don't need any more identity verification evidence.

## Section A

The following information is necessary for you to obtain an illustration from AEGON's online services.

Are any benefits to be in relation to a mortgage?

Yes  No

### First life to be assured (1st life)

Forename(s)

Surname

Date of birth (dd/mm/yyyy)

Sex

Male  Female

**Tobacco and nicotine usage** (If you tell us that you've smoked tobacco or used any other tobacco or nicotine products in the last 12 months, you'll need to answer more questions about this in section 5.)

Do you currently smoke or have you, in the last 12 months, smoked or used any nicotine products, such as gum or patches?

Yes  No

If 'No', we may ask for a simple medical test to confirm this.

### Employment basis

- Employed full-time
- Employed part-time over 16 hours
- Employed part-time under 16 hours
- Self-employed
- Unemployed

Occupation

Industry

### Second life to be assured (2nd life)

Forename(s)

Surname

Date of birth (dd/mm/yyyy)

Sex

Male  Female

**Tobacco and nicotine usage** (If you tell us that you've smoked tobacco or used any other tobacco or nicotine products in the last 12 months, you'll need to answer more questions about this in section 5.)

Do you currently smoke or have you, in the last 12 months, smoked or used any nicotine products, such as gum or patches?

Yes  No

If 'No', we may ask for a simple medical test to confirm this.

### Employment basis

- Employed full-time
- Employed part-time over 16 hours
- Employed part-time under 16 hours
- Self-employed
- Unemployed

Occupation

Industry

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

### Personal Protection menu

Please fill in the tables below for the benefits your client wants. If your client wants more than one of the same benefit, please fill in the 'Extra benefit' box at the bottom of each table. All benefits that pay out on death must be on the same benefit basis.

Benefit	Benefit basis (please tick one box only)	Benefit amount	Benefit term	Premium type	Total and permanent disability						Additional benefits	* Available if you've chosen a five-year term. † Available if you've chosen a five-year term and reviewable premiums.		
					Not required		Own occupation		Any occupation				Activities of daily living	
					1st life	2nd life	1st life	2nd life	1st life	2nd life			1st life	2nd life
Life protection	1st life	£	Years or to age	Guaranteed	<input checked="" type="checkbox"/>							<input type="checkbox"/> Renewal option* <input type="checkbox"/> Indexation option		
	2nd life													
	Joint life 1st claim													
	Joint life 2nd claim													
Critical illness protection	1st life	£	Years or to age	Guaranteed Reviewable	<input type="checkbox"/> <input type="checkbox"/>		<input checked="" type="checkbox"/>					<input type="checkbox"/> Renewal option† <input type="checkbox"/> Indexation option		
	2nd life													
	Joint life 1st claim													
	Joint life 2nd claim													
Life with critical illness protection	1st life	£	Years or to age	Guaranteed Reviewable	<input type="checkbox"/> <input type="checkbox"/>		<input checked="" type="checkbox"/>					<input type="checkbox"/> Renewal option† <input type="checkbox"/> Indexation option		
	2nd life													
	Joint life 1st claim													
	Joint life 2nd claim													
Family income benefit	1st life	£ a year	Years	Guaranteed	<input checked="" type="checkbox"/>							<input type="checkbox"/> Indexation option		
	2nd life													
	Joint life 1st claim													
	Joint life 2nd claim													
Critical illness family income benefit	1st life	£ a year	Years	Reviewable	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>					<input type="checkbox"/> Indexation option		
	2nd life													
	Joint life 1st claim													
	Joint life 2nd claim													
Life with critical illness family income benefit	1st life	£ a year	Years	Reviewable	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>					<input type="checkbox"/> Indexation option		
	2nd life													
	Joint life 1st claim													
	Joint life 2nd claim													
Gift inter vivos	1st life	£	7 years	Guaranteed	<input checked="" type="checkbox"/>							<input type="checkbox"/> Legislation option		
	2nd life													
Gift inter vivos	1st life	£	7 years	Guaranteed	<input checked="" type="checkbox"/>							<input type="checkbox"/> Legislation option		
	2nd life													
Extra benefit														

- All critical illness benefits automatically include total and permanent disability. The usual definition of total and permanent disability is 'own occupation'. Where this isn't available, for example due to the life to be assured's occupation, we'll offer the best definition we can. If your client doesn't want this benefit then please choose 'Not required' from the table above. If your client wants to include the benefit but with the 'any occupation' or 'activities of daily living' definitions of disability, please tick the relevant box above.
- If your client chooses life protection or family income benefit then the attaching total and permanent disability benefit will be on a reviewable premium basis. For all other benefits, the total and permanent disability benefit will be on the same premium basis as the main benefit premium.
- Please note: if your client wants waiver of premium, please fill in the relevant section on page 5.
- Please make sure you collect full details for each benefit your client chooses.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

**Personal protection menu – (continued)**

Benefit	Benefit basis (please tick one box only)	Benefit amount	Benefit term	Premium type	Total and permanent disability						
					Not required		Own occupation		Any occupation		Activities of daily living
					1st life	2nd life	1st life	2nd life	1st life	2nd life	
Reducing life protection	1st life <input type="checkbox"/> 2nd life <input type="checkbox"/> Joint life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/>	Guaranteed <input checked="" type="checkbox"/>							
Reducing critical illness protection	1st life <input type="checkbox"/> 2nd life <input type="checkbox"/> Joint life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	<input checked="" type="checkbox"/>						
Reducing life with critical illness protection	1st life <input type="checkbox"/> 2nd life <input type="checkbox"/> Joint life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	<input checked="" type="checkbox"/>						
Extra benefit											

- All critical illness benefits automatically include total and permanent disability. The usual definition of total and permanent disability is 'own occupation'. Where this isn't available, for example due to the life to be assured's occupation, we'll offer the best definition we can. If your client doesn't want this benefit then please choose 'Not required' from the table above. If your client wants to include the benefit but with the 'any occupation' or 'activities of daily living' definitions of disability, please tick the relevant box above.
- If your client chooses reducing life protection then the attaching total and permanent disability benefit will be on a reviewable premium basis. For all other benefits, the total and permanent disability benefit will be on the same premium basis as the main benefit premium. ■ Please note: if your client wants waiver of premium, please fill in the relevant section on page 5. ■ Please make sure you collect full details for each benefit your client chooses.

**Income protection**

Please only fill in the table below if your client wants income protection. If your client wants a second income protection benefit with a different deferred period, please fill in the 'Extra benefit' box at the bottom of this table.

Benefit basis	Benefit amount*	Benefit term	Premium type	Definition of incapacity**			Deferred period† (in weeks)	Do you have existing cover	If 'Yes': What is the existing benefit amount?	If 'Yes': How much of this cover do you intend to cancel?	Indexation option
				Own occupation	Any suited occupation	Activities of daily work					
Income protection 1st life <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>				4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>
Income protection 2nd life <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>				4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>
Extra benefit 1st life <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>				4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>				<input type="checkbox"/>
Extra benefit 2nd life <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>				4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>				<input type="checkbox"/>

\*The total of all income protection benefits payable is limited to 55% of income. If the life to be assured isn't in paid employment (for example a houseperson or unemployed), the total maximum benefit entitlement can't be greater than £1,250 a month. †The four and eight week deferred periods aren't available if the life to be assured isn't in paid employment (for example a houseperson or unemployed).

\*\*If the life to be assured isn't in paid employment (for example a houseperson or unemployed), the activities of daily work definition will apply.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## Income protection

You only need to complete this section if you're applying for income protection.

### 1st life

Employed yearly earned income:

£

Self-employed net taxable earnings as shown on their Self Assessment tax form:

£  Year 1    £  Year 2

£  Year 3

### 2nd life

Employed yearly earned income:

£

Self-employed net taxable earnings as shown on their Self Assessment tax form:

£  Year 1    £  Year 2

£  Year 3

## Premium details (to be completed for all benefits)

Premium frequency (by Direct Debit):  monthly     yearly

£

Premium – only fill in this box if one of the benefits is premium-driven.

## Waiver of premium

If income protection is chosen then waiver of premium is automatically included and you don't need to complete this section.

If income protection is not chosen, the deferred period will start from the date of incapacity and will be 26 weeks. Please select the definition of incapacity required.

### 1st life

Benefit required  Yes     No

Please tick one definition of incapacity only.

Own occupation     Any suited occupation

Activities of daily work

### 2nd life

Benefit required  Yes     No

Please tick one definition of incapacity only.

Own occupation     Any suited occupation

Activities of daily work

## Commission details

Please note that the commission details entered at illustration stage will be carried through to new business.

Agency number (this is your UAN and comprises of 3 letters and 3 numbers)

Is this application being provided for the adviser's own use, for example the intermediary or their appointed representative, employee, relative, or a relative of an employee of the intermediary?

Yes     No

Initial plus renewal (Indemnity)  
Lump sum paid then renewal commission paid after the indemnity period.

Initial plus renewal (Non-Indemnity)  
Paid in regular instalments over the initial period then renewal commission paid after the initial period.

Level  
Paid in regular instalments throughout the life of the policy.

Would you like to give up any commission?

Yes     No

If yes, what percentage do you want to give up?

%

## Section B

The following information is necessary in order for you to progress your illustration to new business.

Is there an insurable interest between life 1 and life 2? (for example spouse/civil partner, shared dependent children, joint domestic mortgage, living with partner, joint loan)

Please note: only answer this question if joint cover is being applied for.

Yes  No

Has the 'Your online application – what happens next?' section from the back of this form been given to your client?

Yes  No

### 'Source of funds' concession

Money laundering guidance includes a 'source of funds' concession for 'reduced risk' business such as AEGON protection business. Where the policyholder(s) and the premium payer are the same, the 'source of funds' concession allows us to rely on a cheque or Direct Debit instruction from a UK bank account, in the policyholder(s) individual or joint names, to provide evidence of identity.

Is the 'source of funds' concession being applied for this application?

Yes  No

## 1. Personal details – additional

### First life to be assured (1st life)

Title

(Mr/Mrs/Miss/Ms/Dr)

Previous surname (if changed in the last five years)

Marital status (tick one box only)

Single  Married  Civil partner  Divorced  
 Separated  Widowed  Engaged

Total yearly earnings

£

(You don't need to answer this question if you've already done so in the 'Income protection' section.)

### Second life to be assured (2nd life)

Title

(Mr/Mrs/Miss/Ms/Dr)

Previous surname (if changed in the last five years)

Marital status (tick one box only)

Single  Married  Civil partner  Divorced  
 Separated  Widowed  Engaged

What is your relationship with the first life to be assured?

Spouse/Civil partner  Living with partner  Joint loan  
 Shared dependent children  Joint domestic mortgage

Total yearly earnings

£

(You don't need to answer this question if you've already done so in the 'Income protection' section.)

## 2. Contact details of life/lives to be assured – additional

### 1st life

Address

Postcode

Daytime phone number

Alternative phone number

### 2nd life

Address

You only need to fill out the following if your contact details are different from those of the first life to be assured.

Postcode

Daytime phone number

Alternative phone number

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

### 3. Mortgage details

If any of the benefits are to be in relation to a mortgage please fill in the following.

Purpose of loan

- Remortgage of main residence  
 To buy main residence       To improve main residence

Other (please provide details of the purpose of the loan)

  

Type of mortgage (please tick one box only)

- New mortgage       Existing mortgage

Amount of mortgage or loan

£

Term of mortgage or loan

years

Name of lender

Mortgage/loan interest rate

%

Address of mortgaged property

- Same as first life address

Other

  
  

Postcode

Do you want free cover? (for new mortgages only)

- Yes       No

### 4. Income protection details

You only need to complete this section if you're applying for income protection.

#### 1st life

In the event of incapacity, would you receive income from your work?

- Yes       No

Would this income from work continue after the end of the deferred period you've chosen?  Yes       No

If 'Yes', please specify:

% of salary received

%

How long would payment be received?

#### 2nd life

In the event of incapacity, would you receive income from your work?

- Yes       No

Would this income from work continue after the end of the deferred period you've chosen?  Yes       No

If 'Yes', please specify:

% of salary received

%

How long would payment be received?

### 5. Medical details

Please answer the following questions for all types of benefit.

You must not assume that we'll write to your doctor.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

#### 1st life

(i) How tall are you?

m       cms

ft       inches

(ii) How much do you currently weigh?

kgs

st       lbs

#### 2nd life

(i) How tall are you?

m       cms

ft       inches

(ii) How much do you currently weigh?

kgs

st       lbs

Have you been registered with a doctor in the UK for the past 12 months?  Yes       No

Have you been registered with a doctor in the UK for the past 12 months?  Yes       No

## 5. Medical details – *continued*

Name of current doctor
Surgery name
Address
Postcode
Phone number

Name of current doctor
Surgery name
Address
Postcode
Phone number

Have you been registered with your current doctor for more than 12 months?  Yes  No

If 'No', please give your previous doctor's details below.

Name of previous doctor
Surgery name
Address
Postcode
Phone number

Have you been registered with your current doctor for more than 12 months?  Yes  No

If 'No', please give your previous doctor's details below.

Name of previous doctor
Surgery name
Address
Postcode
Phone number

### Tobacco and/or nicotine use

If you've told us in section A of this form that you've smoked or used any type of tobacco or nicotine product in the last 12 months including, but not limited to, cigarettes, cigars, nicotine gum/patches or pipe/rolled tobacco, please answer the following questions.

Has your usage been limited solely to nicotine patches or nicotine gum in the last 12 months?

If 'No', please tell us the type and average amount you smoke or use a day. For pipe and rolled tobacco, give the number of ounces/grams a day.

If you have told us that you have not smoked or used any type of tobacco or nicotine product in the last 12 months, we may ask for a simple medical test to confirm this.

#### 1st life

Yes  No

Type

Amount

Note 1 ounce = 28 grams

#### 2nd life

Yes  No

Type

Amount

Note 1 ounce = 28 grams

### Alcohol consumption

How many units of alcohol do you drink on average each week? (One pint of beer = 2.5 units, one 330ml bottle of beer = 1.5 units, one 175ml glass of wine = 2 units, one measure of spirits = 1 unit).

If you don't drink alcohol please enter 0.

units

units

Have you ever been advised to drink less/no alcohol?

If 'Yes', please give full details of when and why this occurred, how many units you were drinking at the time, the results of any investigations and any treatment you received.

Yes  No


Yes  No


Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 6. Personal questions

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

Please note: you only need to answer these questions if you're applying for either or both of the following benefits – income protection or total and permanent disability benefit.

### Occupation

Please indicate whether your occupation involves the following duties and give details where applicable:

	1st life	2nd life
<b>Manual work, for example lifting, carrying, working with machinery or tools</b> If 'Yes', please give full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average daily % of duties <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average daily % of duties <input type="text"/> <input type="text"/> <input type="text"/>
<b>Driving</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> Average yearly business mileage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> Average yearly business mileage
<b>Work at heights</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average % of time spent at heights <input type="text"/> m Average height in metres	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average % of time spent at heights <input type="text"/> m Average height in metres

Please answer the following questions for all types of benefit.

### Travel

In the next 12 months do you intend to live, work or travel abroad, or have you done so in the past five years?

**Please note:** you don't have to tell us about holidays if they total less than 30 days in any 12-month period.

#### 1st life

Yes  No

If 'Yes', please fill in the table below:

#### 2nd life

Yes  No

If 'Yes', please fill in the table overleaf:

#### 1st life

	Country/Countries	Reason for visit (Choose from Lived abroad, Moving abroad, Business/Work, Holiday/Leisure)	Length of visit (in days)
Future travel/residence (next 12 months)			
Past travel/residence (last five years)			

You only need to answer the question below if you're applying for total and permanent disability or income protection benefits.

How many days in total do you expect to spend outside the United Kingdom for business/work reasons in the next 12 months?

## 6. Personal questions – *continued*

### Travel (*continued*)

#### 2nd life

	Country/Countries	Reason for visit (Choose from Lived abroad, Moving abroad, Business/Work, Holiday/Leisure)	Length of visit (in days)
Future travel/residence (next 12 months)			
Past travel/residence (last five years)			

You only need to answer the question below if you're applying for total and permanent disability or income protection benefits.

How many days in total do you expect to spend outside the United Kingdom for business/work reasons in the next 12 months?

### Leisure

**Do you intend to take part in any hazardous activity?  
Don't include one-off events such as a parachute jump for charity.**

If 'Yes', please tick all that apply. Questionnaires for each of these pursuits are available on our website, [www.aegon.co.uk/adviser](http://www.aegon.co.uk/adviser). Filling in these will help speed up the underwriting process. If you don't have access to these questionnaires, please provide full details of your activities in the 'Details' section below.

#### Details:

Please give full details, including the activity you take part in, how often you take part in this activity, details of any related qualifications and any equipment you use.

#### 1st life

Yes  No

- Aviation (other than as a fare-paying passenger on a licensed airline)
- Motor sports
- Mountaineering (other than hill walking, trekking, abseiling, artificial wall climbing)
- Sports diving
- Other (give details below)


#### 2nd life

Yes  No

- Aviation (other than as a fare-paying passenger on a licensed airline)
- Motor sports
- Mountaineering (other than hill walking, trekking, abseiling, artificial wall climbing)
- Sports diving
- Other (give details below)


Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 6. Personal questions – *continued*

### Other protection policies

#### 1st life

Does the total amount of protection under all your existing policies, together with this application and any pending or concurrent applications exceed £800,000 for life cover or £500,000 for critical illness or total and permanent disability (TPD)?  Yes  No

If 'Yes', please answer the questions below:

Please give details of protection already in force (please include any existing cover with us):

	Policy benefit(s)*	Amount	Reason for protection	Company
1				
2				
3				
4				
5				

\*For example, Life cover/Death or earlier critical illness cover (no TPD)/Death or earlier critical illness cover (with TPD)/Critical illness cover (no TPD)/Critical illness cover (with TPD)/TPD

Is any of your existing protection being cancelled?  Yes  No

If 'Yes', please provide details of which protection is to be cancelled, including the name of the insurance company and the policy number.


Please give details of protection being applied for (please include any other applications to us):

	Policy benefit(s)*	Amount	Reason for protection	Company
1				
2				
3				
4				
5				

\*For example, Life cover/Death or earlier critical illness cover (no TPD)/Death or earlier critical illness cover (with TPD)/Critical illness cover (no TPD)/Critical illness cover (with TPD)/TPD

Is the intention that all of these applications will go in force if accepted?  Yes  No

If 'No', please give full details.


## 6. Personal questions – *continued*

### Other protection policies (*continued*)

#### 2nd life

Does the total amount of protection under all your existing policies, together with this application and any pending or concurrent applications exceed £800,000 for life cover or £500,000 for critical illness or total and permanent disability (TPD)?  Yes  No

If 'Yes', please answer the questions below:

Please give details of protection already in force (please include any existing cover with us):

	Policy benefit(s)*	Amount	Reason for protection	Company
1				
2				
3				
4				
5				

\*For example, Life cover/Death or earlier critical illness cover (no TPD)/Death or earlier critical illness cover (with TPD)/Critical illness cover (no TPD)/Critical illness cover (with TPD)/TPD

Is any of your existing protection being cancelled?

Yes  No

If 'Yes', please provide details of which protection is to be cancelled, including the name of the insurance company and the policy number.


Please give details of protection being applied for (please include any other applications to us):

	Policy benefit(s)*	Amount	Reason for protection	Company
1				
2				
3				
4				
5				

\*For example, Life cover/Death or earlier critical illness cover (no TPD)/Death or earlier critical illness cover (with TPD)/Critical illness cover (no TPD)/Critical illness cover (with TPD)/TPD

Is the intention that all of these applications will go in force if accepted?

Yes  No

If 'No', please give full details.


Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 7. Health questions

Please make sure that you answer all of the questions honestly and accurately. If you're in any doubt about the information we require, you should give full details.

In line with the Association of British Insurers' policy on genetics and insurance, you don't need to tell us about any genetic test result you've had if this application, taken together with any other insurance policies you already have, totals £500,000 or less for life insurance, £30,000 or less for income protection insurance or £300,000 or less for other types of insurance.

Above these limits, you may need to tell us about certain genetic test results when applying for insurance. We'll only be interested in genetic test results where the government's Genetics and Insurance Committee (GAIC) has approved them for insurers to use. If you think this may apply to you, please ask us for details of the current position.

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 tell us about a genetic test result, which shows that you haven't inherited a genetic disorder, then we'll take this into account in setting your premium, provided your clinical geneticist confirms that the test result indicates a reduced risk of developing the inherited disease.

**You must not partially disclose information when answering any questions or assume that we'll write to your doctor.**

When answering the following health questions you don't need to tell us about common colds, influenza, hay fever, sinus trouble, wisdom teeth, vasectomy or shingles.

HIV/AIDS	1st life	2nd life
<p><b>Have you ever tested positive for HIV, hepatitis B or C, or are you waiting for the results of such a test?</b></p> <p>Please note: if the result is negative, the fact of having an HIV test will not, of itself, have any effect on your acceptance terms for insurance.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/> I've tested positive for HIV</p> <p><input type="checkbox"/> I'm waiting for an HIV test result</p> <p><input type="checkbox"/> I've tested positive for hepatitis B or C</p> <p><input type="checkbox"/> I'm waiting for a hepatitis B or C test result</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/> I've tested positive for HIV</p> <p><input type="checkbox"/> I'm waiting for an HIV test result</p> <p><input type="checkbox"/> I've tested positive for hepatitis B or C</p> <p><input type="checkbox"/> I'm waiting for a hepatitis B or C test result</p>
<p><b>Within the last five years have you tested positive or been treated for any disease which was transmitted sexually?</b></p> <p>If you'd prefer to write to our Chief Medical Officer at our head office to answer this question, please tick the box opposite.</p> <p>If 'Yes', please give full details, including the duration of illness, investigations, date of diagnosis and treatment received.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>

## 7. Health questions – *continued*

**Within the last five years have you been exposed to the risk of HIV infection?**

**Please note: HIV infection can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union.**

If you'd prefer to write to our Chief Medical Officer at our head office to answer this question, please tick the box opposite.

If 'Yes', please give full details, including dates.

### 1st life

Yes  No


### 2nd life

Yes  No


If you want to write in confidence to the Chief Medical Officer, please send your details on a separate piece of paper direct to our Chief Medical Officer at AEGON, Ballam Road, Lytham St Annes, Lancashire FY8 4JZ, giving your full name and date of birth. Please make sure you sign and date these details.

**Have you ever taken or injected any drugs that haven't been prescribed by a doctor?**

If you want, you can fill in and return a drugs questionnaire. These are available on our website, [www.aegon.co.uk/adviser](http://www.aegon.co.uk/adviser)

Please confirm the name of the drug.

Do you currently use this drug?

If 'No', when did you last use this drug (mm/yyyy)?

How many times a month do you use/did you use this drug?

Yes  No

Yes  No

Yes  No

Yes  No

**Do you now have, or have you ever had, any of the following:**

**Angina, heart attack, stroke, transient ischaemic attack (TIA), brain haemorrhage or brain injury?**

Please give the precise medical diagnosis.

When were you diagnosed with this condition (mm/yyyy)?

How many times have you suffered from this condition/ how many attacks have you had?

When did you last suffer from this condition/when was your last attack (mm/yyyy)?

Have you made a full recovery?

If 'No', please give full details.

Yes  No

Yes  No


Yes  No

Yes  No


Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 7. Health questions – *continued*

Do you now have, or have you ever had, any of the following:

**Chest pain, palpitations, heart murmur or any disease or abnormality of your heart, pulse, veins or arteries?**

Please give the precise medical diagnosis.

When were you diagnosed with this condition (mm/yyyy)?

Have you had any medical investigations or hospital admissions in relation to this condition? Please note: investigations include GP consultations, blood tests, ECG etc.

Please give full details, including the results of any investigations and details of any underlying cause identified.

How many times have you suffered from this condition?

Have you had surgery in relation to this condition?

If 'Yes', when was the surgery (mm/yyyy)?

Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?

If 'No', please give full details.

When were your last symptoms (mm/yyyy)?

**1st life**

Yes  No



Yes  No  Awaiting

  
  



Yes  No

Yes  No

  
  



**2nd life**

Yes  No



Yes  No  Awaiting

  
  



Yes  No

Yes  No

  
  



**Cancer, tumour, Hodgkin's disease, lymphoma or leukaemia?**

Please give the precise medical diagnosis.

When were you diagnosed with this condition (mm/yyyy)?

When did you last receive treatment for this condition (mm/yyyy)? Please note: treatment includes surgery/chemotherapy/radiotherapy/medication.

How many times have you suffered from this condition?

Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?

If 'No', please give full details.

Yes  No




Yes  No

  
  


Yes  No




Yes  No

## 7. Health questions – *continued*

Do you now have, or have you ever had, any of the following:

	1st life	2nd life
<p><b>Diabetes or sugar in the urine?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>
<p><b>Any condition of the nervous system such as epilepsy, fits or blackouts, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, cerebral palsy or paralysis?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p> <p>The following questions are for epilepsy, fits or blackouts only.</p> <p>On average, how many attacks do you have in a year?</p> <p>When was your last attack (mm/yyyy)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>
<p><b>Mental illness that has required referral to a hospital, community mental health team or psychiatrist?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p> <p>How many times have you suffered from this condition?</p> <p>When did you last suffer from this condition (mm/yyyy)?</p> <p>When did you last have any treatment for this condition (mm/yyyy)? Please note: treatment includes medication, counselling etc.</p> <p>How many days have you taken off work in the last five years as a result of this condition?</p> <p>Have you ever attempted suicide?</p> <p>If 'Yes', how many times and when was the last time?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 7. Health questions – *continued*

Do you now have, or have you ever had, any of the following:

**Any disorder of the eyes (including blurred or double vision) or the ears (including impaired hearing)? You can ignore sight problems corrected by glasses or contact lenses, or hearing problems corrected by hearing aids.**

Please give the precise medical diagnosis.

When were you diagnosed with this condition (mm/yyyy)?

What caused this condition (eg congenital/from birth, accident/injury, disease/illness)?

Have you had surgery in relation to this condition?

Do you have any residual vision/hearing impairment as a result of this condition?

Which eye or ear is/was affected?

How many times have you suffered from this condition?

When were your last symptoms (mm/yyyy)?

### 1st life

Yes  No

Yes  No

Yes  No

### 2nd life

Yes  No

Yes  No

Yes  No

**Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:**

**Raised blood pressure?**

When were you first noted to have raised blood pressure (mm/yyyy)?

How many different types of medication do you take for your raised blood pressure?

If you don't take any medication, please give full details of your raised blood pressure condition including the results of any investigations performed, whether your blood pressure returned to normal without treatment and details of any follow-up required.

Have you ever not taken or stopped your medication without your doctor's approval?

Has your medication changed, the dosage increased or have you been referred for further investigation, other than regular follow-up checks, in the last six months?

Yes  No

Yes  No

Yes  No

Yes  No

## 7. Health questions – *continued*

**Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:**

### **Raised blood pressure? (*continued*)**

When did you last have your blood pressure checked by a medical practitioner (mm/yyyy)?

Do you know what your blood pressure was when it was last checked by a medical practitioner?

If 'Yes', what was it?

Systolic /  
Diastolic

#### **1st life**

Yes  No

 / 

#### **2nd life**

Yes  No

 / 

### **Raised cholesterol?**

Please give full details.

Yes  No

  


Yes  No

  


### **A lump, growth or cyst of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size?**

Please give the precise medical diagnosis.

Please confirm the exact site of the cyst, lump, lesion or growth.

When were you diagnosed with this condition (mm/yyyy)?

Has the cyst, lump, lesion or growth been completely removed?

Has the cyst, lump, lesion or growth been confirmed as benign (non-cancerous)?

Are you currently receiving follow-up checks?

If 'Yes', please give the date of the next follow-up (mm/yyyy).

Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?

If 'No', please give full details.

Yes  No




Yes  No

Yes  No

Yes  No

Yes  No

  


Yes  No




Yes  No

Yes  No

Yes  No

Yes  No

  


### **Numbness, tingling, tremor, temporary loss of muscle power, or loss of balance or co-ordination?**

Please give the precise medical diagnosis.

When were you diagnosed with this condition (mm/yyyy)?

Please give any underlying cause, if applicable.

How many times have you suffered from this condition?

Have you fully recovered with no ongoing symptoms, treatment or follow-up required?

If 'No', please give full details.

Yes  No





Yes  No

  


Yes  No





Yes  No

## 7. Health questions – *continued*

Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:

	1st life	2nd life
<p><b>Asthma, bronchitis or any other chest or lung disorder?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p> <p>How many times have you suffered from this condition?</p> <p>When did you last experience symptoms or take treatment for this condition (mm/yyyy)?</p> <p>Have you been admitted to hospital in the last two years?</p> <p>How many courses of steroid tablets (for example Prednisolone) have you taken in the last two years?</p> <p>How many days have you taken off work in the last 12 months as a result of this condition?</p> <p>Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?</p> <p>If 'No', please give full details.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>
<p><b>Anxiety, depression, stress, fatigue or any form of nervous or mental disorder, including work-related stress?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you first diagnosed with this condition (mm/yyyy)?</p> <p>Are you currently suffering from this condition?</p> <p>Are you currently receiving medication and/or treatment or counselling?</p> <p>Have you ever received inpatient treatment due to this condition?</p> <p>Have you ever received care by a psychiatrist or other medical professional other than your GP/practice nurse, or are you waiting to do so?</p> <p>How many times have you suffered from this condition?</p> <p>When did you last suffer from this condition or receive treatment/counselling (mm/yyyy)?</p> <p>How many days have you taken off work in the last five years as a result of this condition?</p> <p>Have you ever attempted suicide?</p> <p>If 'Yes', how many suicide attempts have you made and when was your last attempt?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>



Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 7. Health questions – *continued*

Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:

	1st life	2nd life
<p><b>Any disorder of the kidney, bladder, prostate or genito-urinary system, including blood or protein in the urine?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p> <p>Have you had any medical investigations in relation to this condition?</p> <p>Please give any underlying cause, if applicable.</p> <p>Have you had surgery in relation to this condition?</p> <p>How many times have you suffered from this condition?</p> <p>Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?</p> <p>If 'No', please give full details.</p> <p>When were your last symptoms (mm/yyyy)?</p> <p>How many days have you taken off work in the last 12 months as a result of this condition?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Awaited</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Awaited</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Awaited</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Awaited</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>
<p><b>Any arthritis, gout, joint or muscle problems, including the knee(s), shoulder(s), neck, back or spine?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p> <p>Are you currently unable to work or carry out your usual daily activities?</p> <p>Please give any underlying cause, if applicable.</p> <p>Have you had surgery in relation to this condition?</p> <p>If 'Yes/Awaited', please give full details of the surgery including joint(s) involved and date.</p> <p>How many times have you suffered from this condition?</p> <p>Which joint(s)/part(s) of the body does this condition affect?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Awaited</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Awaited</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>

The full range of point of sale questionnaires can be downloaded from [www.aegon.co.uk/adviser](http://www.aegon.co.uk/adviser)

## 7. Health questions – *continued*

Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:

**Any arthritis, gout, joint or muscle problems, including the knee(s), shoulder(s), neck, back or spine? (continued)**

Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?

If 'No', please give full details.

When were your last symptoms (mm/yyyy)?

How many days have you taken off work in the last five years as a result of this condition?

The following questions are for arthritis or gout only.

On average how many attacks do you have each year?

Which of the following best describes your condition? (Please tick one option only)

Pain/stiffness (mainly early morning/late evening), no limitation of movement in affected joints, no deformity of joints, able to walk unaided.

Pain/stiffness isn't limited to early morning/late evening, some limitation of movement in affected joints, some assistive devices needed, eg a device to open a screw bottle top, able to walk unaided.

No complete freedom from stiffness/pain, serious restriction of movement in affected joints, marked deformity of joints, need help with day-to-day activities, regularly use walking aids.

**1st life**

Yes  No

  





**2nd life**

Yes  No

  





(This question is for both males and females)

**Any breast disorders, for example lumps, cysts, nipple discharge or inverted nipple, or an abnormal mammogram?**

Please give the precise medical diagnosis.

When were you diagnosed with this condition (mm/yyyy)?

Has this been fully investigated?

If 'Yes', please give full details.

Have you been diagnosed with a cyst/lump?

For cyst/lump – has the cyst, lump, lesion or growth been completely removed?

For cyst/lump – has the cyst, lump, lesion or growth been confirmed as benign (non-cancerous)?

Are you currently receiving follow-up checks?

If 'Yes', please give the date of the next follow-up (mm/yyyy).

Yes  No



Yes  No

  


Yes  No

Yes  No

Yes  No

Yes  No

Yes  No



Yes  No

  


Yes  No

Yes  No

Yes  No

Yes  No

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## 7. Health questions –continued

Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:

(This question is for females only)

**An abnormal cervical smear or other gynaecological disorder from which you haven't fully recovered and/or been discharged from follow-up?**

Please give the precise medical diagnosis.

When did you first suffer from this condition (mm/yyyy)?

When were your last symptoms (mm/yyyy)?

What investigations have you had in relation to this condition?  
Please note: investigations include GP consultations, blood tests, scans etc.

What treatment have you had in relation to this condition?  
Please note: treatment includes surgery, medication etc.

Has the condition been confirmed as benign (non-cancerous)?

Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications and been discharged from follow-up?

If 'No', please give full details.

The following questions are for borderline/abnormal smear tests only.

Please tell us the CIN (Cervical Intraepithelial Neoplasia) grading if known.

Have all of your subsequent smear tests been normal?

1st life

Yes  No

  
  

Yes  No

Yes  No

  

Yes  No

2nd life

Yes  No

  
  

Yes  No

Yes  No

  

Yes  No

## 7. Health questions – *continued*

**To the best of your knowledge, have any of your parents, brothers or sisters, before the age of 65, died or suffered from any of the diseases/disorders indicated below?**

### 1st life

Yes  No

### 2nd life

Yes  No

If 'Yes', please fill in the table below:

#### 1st life

Disease/Disorder	Relationship	Age at diagnosis	Relationship	Age at diagnosis	Relationship	Age at diagnosis
Heart disease						
Stroke						
Diabetes						
Cancer or tumour (Please give site/type)						
Alzheimer's disease						
Parkinson's disease						
Polycystic kidney disease						
Polyposis of the colon						
Motor neurone disease						
Multiple sclerosis						
Huntington's disease						
Muscular dystrophy						
Hypertrophic cardiomyopathy (HOCM)						
Any other hereditary disorder						

#### 2nd life

Disease/Disorder	Relationship	Age at diagnosis	Relationship	Age at diagnosis	Relationship	Age at diagnosis
Heart disease						
Stroke						
Diabetes						
Cancer or tumour (Please give site/type)						
Alzheimer's disease						
Parkinson's disease						
Polycystic kidney disease						
Polyposis of the colon						
Motor neurone disease						
Multiple sclerosis						
Huntington's disease						
Muscular dystrophy						
Hypertrophic cardiomyopathy (HOCM)						
Any other hereditary disorder						

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Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you are claiming.

## 7. Health questions – *continued*

	1st life	2nd life
<p><b>Are you awaiting the results of any investigations or are you aware of any symptoms or complaints that you haven't consulted a doctor or received treatment for?</b></p> <p>Please tell us the symptoms or complaint you have suffered from.</p> <p>Please give us full details.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>
<p><b>Do you have any other information to give us about any medical investigation, test or consultation, advice, counselling, operation, medication or treatment that you've had or been advised to have or are currently having, but haven't already told us about?</b></p> <p>Please give the precise medical diagnosis.</p> <p>When were you diagnosed with this condition (mm/yyyy)?</p> <p>Have you had any medical investigations or hospital admissions in relation to this condition? Please note: investigations include GP consultations, blood tests, ECG etc.</p> <p>Please give full details, including the results of any investigations and details of any underlying cause identified.</p> <p>How many times have you suffered from this condition?</p> <p>Have you had surgery in relation to this condition?</p> <p>If 'Yes', when was the surgery (mm/yyyy)?</p> <p>Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?</p> <p>If 'No', please give full details.</p> <p>When were your last symptoms (mm/yyyy)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>

**You only need to answer this question if you're applying for critical illness, total and permanent disability or income protection benefits. Please note: you don't have to give details relating to anything you've already told us about.**

	1st life	2nd life
<p><b>During the last five years have you been off work or unable to carry out your normal duties due to sickness, accident or injury for more than five days at any one time, other than previously disclosed?</b></p> <p>Please give the reason for the time off, dates, duration, whether any medical advice was sought and whether any treatment was given.</p> <p>Have you fully recovered with no ongoing symptoms, treatment, residual problems or complications?</p> <p>If 'No', please give full details.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="text"/></p> <p><input type="text"/></p>

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## 8. Client consent

Do you want to see any medical report before it is supplied to AEGON?

**1st life**     Yes     No

**2nd life**     Yes     No

We may share your personal information with companies in the AEGON UK plc group. The AEGON UK plc group may tell you about our new products or services from time to time. Where 'AEGON UK plc group' is used, this means Scottish Equitable plc and any associated companies.

Do you want to get such information?

**1st life**     Yes     No

**2nd life**     Yes     No

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## 9. Trust details

Will you be writing this policy under trust?

Yes     No

We'll send you a draft of our flexible trust deed together with the policy schedule. Please don't submit a trust form before receiving the Policy schedule.

**Note:** Business trusts can't be used with this application.

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## 10. Policy start date

On risk immediately on acceptance at standard terms

To be advised (If the case has been accepted, you can input a start date later through the 'Recall' facility)

A future start date

(dd/mm/yyyy)

(Acceptance terms are valid for a maximum of 30 days)

The following information should be given to your client.

## Your online application – what happens next?

You've chosen to apply online for a protection policy with AEGON (a brand name of Scottish Equitable plc). This document will tell you what happens next and contains some important notes for you.

### What happens next?

- Your adviser will now submit your application on your behalf using our online service.
- As soon as we receive your electronic application, a *Confirmation pack* will be sent to the address of the first life to be assured, this will contain details for both lives to be assured if this is a joint application. The *Confirmation pack* will include:
  1. an *Application record* (this will show the information that has been submitted electronically on your behalf)
  2. a *Declaration*
  3. a *Confirmation form*
  4. a prepaid reply envelope

#### Your *Application record*

- Please read this document carefully to make sure all the information is correct. If there are any mistakes or missing information, you should fill in section 1 of the *Confirmation form* and return it to us immediately.

#### Your *Declaration*

- Please read this document carefully as it contains important information and forms part of the basis of a contract between you and AEGON.

#### Your *Confirmation form*

- Please read this document carefully as it forms part of the basis of a contract between you and AEGON.
- Please remember, both life 1 and life 2 (where appropriate) should sign and date the *Confirmation form* and return it to us in the enclosed prepaid return envelope.
- **PLEASE MAKE SURE YOUR ADVISER HAS GIVEN YOU A COPY OF THE KEY FEATURES DOCUMENTATION FOR THIS PRODUCT.**
- **IF WE DON'T RECEIVE A SIGNED AND DATED CONFIRMATION FORM WITHIN 60 DAYS OF THE DATE ON YOUR CONFIRMATION PACK COVERING LETTER THEN:**
  - **YOU WON'T BE COVERED FOR THE PROTECTION BENEFITS YOU'VE CHOSEN**
  - **IF YOUR POLICY HAS ALREADY STARTED THEN IT WILL BE CANCELLED**

### Important notes

It's important that you read and understand the following information:

- The questions we've asked cover the facts that we think are important to our assessment of your application. The information input electronically by your adviser, together with any other information collected, will form part of the application that's submitted to us on your behalf.
- AEGON is the data controller of the personal data that I, or someone on my behalf, give you. We'll use the information you've provided for purposes in connection with the contract (and related services) which you've applied for. This includes the processes of underwriting, administration, claims management and customer complaint handling.
- When answering a question you're personally responsible for making sure you've given complete and accurate information. You shouldn't make any personal assessment about whether the information is relevant or not, or assume that we'll write to your doctor for medical information. If you're in any doubt about the information required, you should give full details.
- You must tell us in writing if there's any change in your circumstances (for example financial interest, health, lifestyle, occupation or employment status and/or recreational activities) between the date you answered the application questions and the start date of your policy. If there's any change in your circumstances at all, you should tell us.
- If you don't give full and accurate information, as detailed above, all the protection provided by the policy could be lost or cancelled in the event of a claim, not just the benefit affected or the benefit that's being claimed under.
- Please be aware that if you're applying for insurance with other companies at the same time, by signing the *Confirmation form* you're consenting to us sending copies of medical reports to these other companies if they ask for them. However, if they ask us for any highly sensitive information, including HIV or genetic test results, we'll ask your specific permission before we send it.
- The *Declaration*, *Confirmation form* and Direct Debit together with the data input electronically, will form the application and therefore the basis of the contract.

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## How to complain

If you ever need to complain, first write to us at:

AEGON  
Ballam Road  
Lytham St Annes  
Lancashire  
FY8 4JZ

If you're not satisfied with our response, you can complain to:

The Financial Ombudsman Service  
South Quay Plaza  
183 Marsh Wall  
London  
E14 9SR

Phone: 0800 0 234 567 or 0300 123 9 123  
[www.financial-ombudsman.org.uk](http://www.financial-ombudsman.org.uk)  
[complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)

Complaining to the Ombudsman won't affect your right to take legal action later on.



## General practitioner's report consent declaration

Application reference

### 1st life to be assured

Name

Date of birth (dd/mm/yyyy)

### 2nd life to be assured

Name

Date of birth (dd/mm/yyyy)

### Important notes

If we need to carry out further underwriting, the policy won't start until we've assessed and accepted your electronic application and the first premium has been paid. If you have a full or quarter birthday (quarter birthdays are at three, six and nine months after a birthday) while the application is being processed, the terms may differ from those originally illustrated. In most instances the premiums will be as originally illustrated. We may offer revised terms, but occasionally we may not be able to offer any terms.

We may ask you to contact your doctor if we're waiting for reports which we've asked for. If we ask you to attend a medical examination or we ask your doctor for a general practitioner's report, we may need to share the application information with another company we've authorised. They'll make the arrangements for the examination to take place and/or to obtain the general practitioner's report.

We may need to send the application and relevant medical reports to our reinsurers for their opinion or agreement to the terms offered, or we may need to send them at a later stage for purposes relating to managing the policy. Please ask us if you want details of any company we use to assess the application.

We have a confidentiality policy in place, which means we hold all medical information securely and access is limited to authorised individuals who need to see it. You're entitled to ask for a copy of our standard policy conditions and/or a copy of your *Application record* and signed *Confirmation form* at any time.

#### Access to medical reports

We may need to get medical reports to support the application. Before we can ask any doctor that you've consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988 (or The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991) (each referred to individually as the Act). Your rights under the Act are as follows:

- You don't need to give your permission, but if you don't, we may not be able to go ahead with the application. This doesn't prevent an application being made to other companies for insurance.

- You can ask to see the report before your doctor returns it to us. If this is the case, we'll tell your doctor to keep the report for 21 days so that you can arrange to see it. If you haven't made arrangements to see the report within this time, your doctor will send the report to us. Once you've seen the report, your consent is required before it can be passed to us.
- If you choose not to see the report at this stage, you may ask your doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.
- If you indicate on this form that you don't want to see the report before it's sent to us, we can ask your doctor for a report without notifying you. However, you can still write to your doctor and ask to see the report before it's sent to us. You'll then have 21 days within which to make arrangements to see the report.
- If you think that any part of the report isn't correct or is misleading, you may ask your doctor to amend it. If your doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if:
  - they feel that it would cause physical or mental harm to you or others
  - it discloses information given by or about another person (apart from another doctor who has attended you), who doesn't want their identity or the information revealed. In these circumstances, your doctor must notify you and you'll then be able to see only the non-confidential parts of the report. If the whole report is affected, your doctor must not send it to us unless you consent to this
- If you ask for a copy of the report under any circumstances, your doctor can charge you a reasonable fee to cover the costs of supplying it.
- The medical report your doctor fills in asks about the following:
  - Your current health:
    - any care, medication or treatment you're currently receiving
    - the results of referrals or tests you're waiting for
    - any time off work in the last three years

## General practitioner's report consent declaration – *continued*

– 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, for example arthritis, rheumatism, back problems or any other disorder of the joints or muscles
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
  - suicidal thoughts or attempts at suicide
  - conditions related to drug or alcohol misuse or smoking or chewing tobacco
- details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
- any blood pressure readings in the last three years
- any history of disease among your parents or brothers or sisters that you have told your doctor about
- If we ask your doctor for a report, we'll ask them 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 and your doctor provide about your health may result in us:
  - refusing to provide insurance
  - increasing premiums above standard rates
  - excluding certain medical conditions
  - setting premiums at standard rates

If you have any questions about your rights under the Act or questions about the process of getting, assessing or storing medical information, please write to Customer Enquiries, AEGON, Ballam Road, Lytham St Annes, Lancashire FY8 4JZ.

**Do you want to see any medical report before it's sent to us?**

Life 1  Yes  No

Life 2  Yes  No

### Declaration

**In this declaration 'I/me' means the life/lives to be assured and 'you' means AEGON.**

- I agree to you asking any doctor I have consulted about my physical or mental health for medical information so you may assess the application. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorise those asked to give medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the date that I signed this form, or at any time after my death to support any claim made on the policy.
- This information can also be used to maintain management information for business analysis.
- By signing this declaration I am allowing you to process the application using the information that I have given. You may also use this information to process any claim made on the policy.
- I have read the declaration, important notes and information relating to my rights under the Act.

### Signature(s) of the life/lives to be assured

**1st life**

 X X

Print name

Date of signature (dd/mm/yyyy)

**2nd life**

 X X

Print name

Date of signature (dd/mm/yyyy)

Please enter your online application reference number

(You'll find this number at the top right-hand side of the online services new business screen.)



Please fill in the whole form using a ballpoint pen and send it to:  
 AEGON,  
 Ballam Road,  
 Lytham St Annes,  
 Lancashire  
 FY8 4JZ



## Instruction to your bank or building society to pay by Direct Debit

Service user number

### Name and full postal address of your bank or building society

To: The Manager

Postcode

### Name(s) of account holder(s)

### Bank/Building society account number

### Branch sort code

-    -

Reference (to be completed by Scottish Equitable plc)

### FOR SCOTTISH EQUITABLE PLC OFFICIAL USE ONLY

This is not part of the instruction to your bank or building society.

Policy number

Life assured

AEGON reference

### Instruction to your bank or building society

Please pay Scottish Equitable plc 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 Scottish Equitable plc and, if so, details will be passed electronically to my bank/building society.

Signature(s)

<b>X</b>	<b>X</b>
<b>X</b>	<b>X</b>

Date (dd/mm/yyyy)

**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, Scottish Equitable plc will notify you three working days in advance of your account being debited or as otherwise agreed. If you request Scottish Equitable plc 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 Scottish Equitable plc 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 Scottish Equitable plc 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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We're proud to be the  
Lead Partner of British Tennis.