



STERLING

Life Limited

APPLICATION FORM

PLEASE READ THIS IMPORTANT NOTE BEFORE COMPLETING THIS APPLICATION FORM

- It is important that all questions are answered truthfully and accurately. Please disclose all relevant facts that could influence or affect the assessment and/or acceptance of the application for insurance, including the amount of premium payable.
- If a policy is issued without all relevant information having been provided, Sterling Life may avoid payment of a claim under the policy. If you are in any doubt as to whether certain information is relevant you should disclose it. If you consider that the response to any of the questions in the application form requires any expert or third party knowledge that you do not have, please indicate this in your answer.
- Sterling Life must be notified, in writing, of any changes to the details provided on the application form, including those relating to health, occupation, pastimes, travel or country of residence that occur before the policy is issued.
- Sterling Life is not liable for the payment of any benefit under the policy until the start date of the Policy has been confirmed and reached and the first premium has been paid.
- On occasion, the faxing of medical reports may help to ensure a speedier assessment of your application. We only accept faxed information direct to a fax machine in a secure area of our building to ensure that we maintain strict confidentiality. If you do not agree to allow the faxing of information, please indicate this by deleting the appropriate section of the Declaration in section G.
- Sterling Life Limited has a confidentiality policy in place, which means that medical information is held securely and access is limited to authorised individuals who need to see it for the purpose of processing your application.
- If a birthday occurs while the application is being processed, the terms may differ from those originally quoted.
- Appointed Representatives, Brokers and Independent Financial Advisers submitting application forms to Sterling Life Limited do not have the authority to conclude contracts on Sterling Life Limited's behalf.
- Unless specifically agreed to the contrary, this insurance shall be subject to English law and the exclusive jurisdiction of the English courts.
- A copy of the policy provisions and completed application form is available on request.

Financial Adviser Company Name:

Agency Number:

PLEASE USE BLOCK CAPITALS WHEN COMPLETING THIS FORM

A Product Required

Product required	Single Life <input type="checkbox"/>	Joint Life 1st death <input type="checkbox"/>
Term (minimum 6 months)	Sum Insured £	Premium (minimum monthly £7.50 / annual £90.00 / single £90.00)
Reason for cover (If policy term is 12 months or less)		

B Personal Details

	First Life	Second Life
Title (Mr/Mrs/Miss/etc)		
Surname		
First name(s)		
Date of birth		
Marital status		
Full address		
	Postcode	Postcode
Contact telephone numbers	Daytime	Daytime
	Mobile	Mobile
Country of birth		
Doctor's name		
Doctor's address		
	Postcode	Postcode
Doctor's telephone number		

C Occupation Details

	First Life	Second Life
Job title		
In which industry do you work?		
If your job involves manual work please indicate percentage	_____ %	_____ %
Details of duties?		
Does your occupation require you to work:		
(i) At heights exceeding 40 feet	yes / no	yes / no
(ii) Overseas	yes / no	yes / no
(iii) Offshore	yes / no	yes / no
(iv) In a hazardous environment	yes / no	yes / no

If the answer to any of Questions (i) to (iv) is "yes", please provide full details in Section I.

D Lifestyle Details

The following questions require "yes/no" answers. If you answer "yes" to any of the questions, please provide full details in Section I.

	1st Life		2nd Life	
	Yes	No	Yes	No
1(a) Have you used any form of tobacco products (including nicotine replacement products) in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1(b) If you smoke cigarettes, cigars or pipe please indicate how many per day.	<input type="text"/>		<input type="text"/>	
2 Please state your average weekly alcohol intake in units. (A unit is a pub measure of wine or spirits, or a half pint of beer, lager or cider).	<input type="text"/>		<input type="text"/>	
3 Are you currently living or residing outside the United Kingdom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 10 years, have you lived, worked or travelled for more than 1 month (in any twelve month period) outside of the United Kingdom, Western Europe, North America, Australia or New Zealand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you intend to live or travel anywhere outside the United Kingdom, Western Europe, North America, Australia or New Zealand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Have you previously, do you currently or are you planning to take part in any of the following activities? Flying (other than as a fare paying passenger), Hang Gliding, Parachuting, Sky Diving, Caving, Potholing, Motor Car Sport, Motor Cycle Sport, Rock Climbing, Mountaineering, Sailing or Powerboat Racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Do you or have you belonged to any of the following groups: Homosexual men, Bisexual men, Intravenous drug users, haemophiliacs, Sexual partners of any of the preceding groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E Medical Details

- In accordance with the Association of British Insurers' policy on Genetics and Insurance, you do not need to tell us about any genetic test result you have had if this application is for Life and/or Critical Illness insurance and, taken together with any other insurance policies you already have, totals to £300,000 or less.
- Above £300,000, you may need to tell us about certain genetic test results when applying for certain types of insurance. We will only be interested in genetic test results where the Government's Genetic and Insurance Committee have approved them for insurers to use. If you think this may apply to you, please ask us for details of the current position.
- You must tell us if you either have a family history of, or are experiencing symptoms of, or are having treatment for a medical condition including any genetically inherited condition.

	1st Life	2nd Life
1(a) What is your height?	<input type="text"/>	<input type="text"/>
1(b) What is your weight?	<input type="text"/>	<input type="text"/>

The following questions require "yes/no" answers. If you answer "yes" to any of the questions, please provide full details in Section I.

	Yes	No	Yes	No
2 Have you ever been advised to reduce your alcohol consumption on medical advice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Have you at any time had, or been advised to have any medical investigations, consultation or treatment for any of the following illnesses or medical conditions:				
(a) Heart Attack, Angina, Heart Murmur or Stroke;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Raised Blood Pressure, Chest Pain, Palpitations or any other disease or abnormality of your heart;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Circulatory Disease, Claudication, Varicose Veins or any other disease or disorder of the circulatory system;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Cancer, Tumour or Leukaemia;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Any type of lump or growth either malignant or benign;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Diabetes or sugar in the urine;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Kidney, Liver or Bladder disease or disorder;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Asthma, Bronchitis or any other type of lung or respiratory disease or disorder;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Multiple Sclerosis, paralysis, numbness or dizziness;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Any disease or disorder of the brain or nervous system or any disease or disorder affecting your muscles;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Any form of mental health disorder including Anxiety, Depression or Stress;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Any disease or disorder of the bowels including Colitis, Crohns Disease or Irritable Bowel Syndrome;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Any disease or disorder of the stomach, gall bladder or pancreas;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Arthritis, joint pains, rheumatism or any other form of neck, back or spinal problems;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Any disease or disorder affecting your ears, hearing or balance or your eyes or vision (not corrected by spectacle or lenses).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Have you ever tested positive for HIV/AIDS or are you awaiting the results of such a test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you ever been tested or treated for any sexually transmitted disease or Hepatitis B or C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Excluding those mentioned above, have you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(a) Had any other illness or medical condition lasting or requiring treatment for more than 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Ever attended any hospital or clinic or had any specialist tests or investigations including those of a routine or minor nature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Are you currently receiving medical care or treatment for any medical or psychiatric condition (e.g. medicine, injections, counselling, diet or advice)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Has any member of your immediate family (parent, brother or sister), been diagnosed with or died from heart disease, stroke, cancer, raised blood pressure, diabetes, multiple sclerosis or kidney disease before the age of 65 or suffered from any hereditary illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F Insurance Details

The following questions require "yes/no" answers. If you answer "yes" to any of the questions, please provide full details in Section I.

	1st Life		2nd Life	
	Yes	No	Yes	No
1 Has any application you have made for life, critical illness or health insurance ever been declined, postponed or subject to an increased premium or other special terms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you any existing life or critical illness insurance cover (Please state details of sum assured, term and reason for cover)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Do you have an application for life or critical illness insurance cover pending or awaiting acceptance (Please state details of sum assured, term and reason for cover)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACCESS TO MEDICAL REPORTS ACT 1988

It may be necessary for us to obtain medical reports to support your application. Before we can ask any doctor that you have consulted to complete a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

- You do not have to give your consent, but if you do not we may be unable to proceed. This does not stop you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you may ask your doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.
- If you consider any aspect of the report to be incorrect or misleading, you may ask your doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he feels that it would cause physical or mental harm to you or others.
- Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give the Company access to this information.
- If you have any questions regarding your rights under the Act or any questions relating to the process of obtaining, assessing or storing medical information, please write to Compliance Department, Sterling Life Limited, Ambassador House, Paradise Road, Richmond upon Thames, Surrey, TW9 1SQ. Tel: 0870 224 2390 and fax: 0870 224 2449

G Declaration (To be signed by the Life (Lives) to be Assured)

- Please sign this declaration once you have read it together with the Important Note at the beginning of this form. If you are unsure as to whether any information should be given, you should provide it.
- I/we declare that all statements made herein are true to the best of my/our knowledge and belief. I/We are aware that the Company will rely upon the statements made herein and the statements made by me/us to any medical examiner appointed by the Company when making this contract.
- I/we will inform you immediately of any changes that occur before the policy starts. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.
- If you are applying for insurance with other companies at the same time, by signing the Declaration you are consenting to copies of medical reports being sent to these other companies at their request. However, if we are approached by another company to provide copies of highly sensitive information we will ask for your specific written permission before doing so.
- To the best of my/our knowledge and belief all the statements made, which includes anything I/We may have said, have been recorded accurately in this application or are attached in a sealed Private and Confidential envelope, and are true and complete. This disclosure will form the basis of the contract.
Please tick if you have attached a Private and Confidential envelope.
- I/we agree to the Company seeking medical information from any doctor who at any time has attended me/us concerning anything which affects my/our physical or mental health, in order to assess my/our application. You may also seek relevant information from other insurers about previous or current applications for life, critical illness or income protection insurance that I/we have applied for. I/We authorise those asked for such information to provide it on production of a copy of this consent. The consent allows the Company to obtain medical reports at any time during the life of the policy or after my/our death to support any claim made on the policy proceeds.
- This information can also be used to maintain management information for business analysis.
- I/we do/do not* object to the information supplied being used to advise me of other products and services offered by the Company. (*Delete the words "do not" if you do not wish to receive literature.)
- I/we agree that a copy of the agreement given in this declaration will have the validity of the original.
- I/we do/do not agree to Sterling Life Limited accepting medical reports faxed directly to the Company from my doctor's surgery. I/We also do not* object to copies of the report being faxed to any other company that I/We have applied to at their request. (*Delete the words "do not" if you do not wish us to fax information.)
- I understand that the Company may make my personal information available to reinsurers and also third party medical providers with whom the Company does business and who have undertaken to keep my personal information confidential.
- By signing this declaration I/we am/are allowing the Company to process my/our application using the information that I/we have provided. This information can also be used to process any claim made on this policy.

I/We have read the Declaration, Important Note and information relating to my/our rights under the Access to Medical Reports Act.

1st Life: *Please tick one box only*

- I wish to see the medical report before it is sent to the Company
- I do not wish to see the report before it is sent to the Company



2nd Life: *Please tick one box only*

- I wish to see the medical report before it is sent to the Company
- I do not wish to see the report before it is sent to the Company



1st Life
Signature

Date

2nd life
Signature

Date



The Policyholder

Complete this section only if the person taking out the policy is not one of the Lives to be Assured and sign the Declaration.

Title (Mr/Mrs/Miss/etc)		Full surname	
Full forenames			
Name of Company (If applicable)			
Full address	Post Code		
Policyholder's relationship to the Life/Lives to be Insured			
Details of Insurable Interest			

Declaration (To be signed by the Policyholder, only if the person taking out the policy is not one of the Lives to be Assured.)

I the person proposing to effect the policy, the Policyholder, have read all the statements made herein and declare that to the best of my knowledge and belief they are true.

I agree that this application and declaration and those statements which have been or shall be made to the Medical Examiner of the Company with reference to this application and subscribed by the person(s) whose life/lives is/are to be assured, shall form the basis of the contract between me and the Company.

Signature

Date



Additional Information

Question number	First life full details and dates	Question number	Second life full details and dates

J Financial Details

SECTION 1 CREDIT/DEBIT CARD DETAILS

Card Number	<input type="text"/>	Card Holder Name	<input type="text"/>
Expiry date	<input type="text"/>	Issue Number	<input type="text"/>
		Signature	<input type="text"/>
			Date <input type="text"/>

SECTION 2 DIRECT DEBIT DETAILS

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

Please fill in the form and send to: Sterling Life Limited, Ambassador House, Paradise Road, Richmond upon Thames, Surrey, TW9 1SQ.



1. Name(s) of account holder(s)	<input type="text"/>	Reference Number To be completed by originator	<input type="text"/>
2. Bank or Building Society account number	<input type="text"/>	Originator's Identification Number	<input type="text" value="9 4 0 1 4 6"/>
3. Branch sort code (from the top right hand corner of your cheque)	<input type="text"/>		

4. Name and full postal address of your Bank or Building Society Branch

To: The Manager	
	Bank or Building Society
Address	
	Postcode

Instruction to your Bank or Building Society

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

Signature(s)	
	Date

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

This guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

- This guarantee is offered by all Banks and Building Societies that 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 amounts to be paid or the payment dates change Sterling Life Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Sterling Life Limited 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.



