Advisers, did you know you can apply online?

You can register and apply online at **https://oa.cirencesterfriendly.co.uk/** alternatively, call our Sales Team to discuss your options on **0800 587 5098**.

For office use only

Ref _____

Income Assured Enhanced

Your Application

Can I apply for Income Assured Enhanced? Yes, if....

- You live in the UK with no immediate intention to live or work permanently abroad
- You are employed or self-employed earning more than £4,550 per year or performing the functions of a bona fide houseperson. A description can be found on page 8
- Your work does not take you outside of the UK for more than 6 months in a year
- You are at least 16 years of age but have not yet reached the age of 60
- You have been registered with a UK GP continuously for the last three years
- Your occupation is not included in our list of occupations we do not cover which can be found on our website www.cirencester-friendly.co.uk
- You pay UK tax on earnings from work (or would, if you were not a houseperson)
- You are currently actively working (not applicable if you are a houseperson)

Please confirm that all these answers are 'yes'. ☐

Due to the current Covid-19 pandemic, please also confirm the following are all true. Please tick here ☐

- I am working my full hours, on full occupational duties and am not in receipt of furlough payments or SEISS. I am also not aware that I am due to be furloughed, made redundant or that my work circumstances are due to change in any way but if they do, I will notify you.
- I am aware that at claim any Benefit payable will be subject to me providing evidence of my taxable earnings, for the 12 months immediately preceding the claim.

Please tick to confirm you have read and understood the following Exclusion, which means that no benefit will be paid in relation to; ☐

Coronavirus / Covid-19, other viral and respiratory tract infections, (to include self-quarantine, of all types, and / or caring for others with these conditions) and associated conditions including post viral fatigue and post viral depression, if you are applying for a 1 week deferred period.

For Financial Adviser use only

Please complete the following information for processing purposes.

Important note regarding Adviser status: As Income Assured Enhanced has an option to build a capital sum you **must** be authorised by the Financial Conduct Authority to give investment advice to your clients on the suitability of this product (CF30).

Adviser's Name and Correspondence Address

FCA Company Ref. No.

FCA Individual Ref. No.

Adviser Code *(If known)* **B**

Tel

Fax

Email
(This will be used for contacting you about the application)

Network Name *(If applicable)*

Commission option: (full details on www.cirencester-friendly.co.uk):

☐ Indemnity ☐ Non Indemnity

☐ Combination ☐ Sacrifice *(not available to protection only applications)*

Confirmation of Verification of Identity and checking of HMT Financial Sanctions list

I/we confirm that:

- the information in this section was obtained by me/us in relation to the customer;
- the evidence I/we have obtained to verify the identity of the customer meets or exceeds the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG;
- the customers' name does not appear on HM Treasury UK Consolidated Financial Sanctions list.
- Where a third party is involved e.g. the customer is not the bank account holder and therefore not the payer of the premiums, or where bank accounts require more than one person to authorise debits e.g. business accounts or joint bank accounts, the identity of the person or persons must be verified and confirmation provided.

Signed:

Name (CAPITALS):

Position:

Date ☐☐/☐☐/☐☐☐☐

PLEASE COMPLETE IN BLACK INK USING BLOCK CAPITALS, ANSWER ALL QUESTIONS AND WHERE APPLICABLE TICK YOUR CHOICE ☑

EXTRA SPACE FOR INFORMATION IS PROVIDED ON PAGE 21

Dear Applicant,

PLEASE ENSURE YOU READ THESE IMPORTANT NOTES BEFORE COMPLETING THE APPLICATION.

- You are applying for an income protection insurance contract and it is very important that you answer all the questions as fully and honestly, to the best of your knowledge and belief, as they are relevant and important and you are responsible for all the answers given. Please complete this form yourself, but if your financial adviser completes it then you must check the answers given for accuracy and completeness. If you are unsure about any question or your answer, please contact us.
- Your answers to the following questions provide us with material facts which enable us to decide if we can offer you a contract of insurance and if so on what terms e.g. standard or with a loading to the premium or restriction to what you can claim for. The Society will rely on what you tell us, so please do not assume that we will clarify or confirm the information provided. If you do not answer all questions fully and honestly this could result in your application being declined, your contract being cancelled and any future claims being refused and any paid benefit being recovered from you.
- The Society reserves the right to postpone or decline your application.
- In the event of any terms being offered by the Society, your Financial Adviser or the Financial Adviser's firm authorised representative will have the authority to accept these on your behalf.

A. Your personal details

1. Have you previously applied to Cirencester Friendly for Membership or are you a current or past Member of the Society? Yes ☐ No ☐

(If 'yes' please provide Membership or previous reference number)

2. Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ *(please specify)*

First Name(s) Surname

3. Address

Postcode

4. Home Telephone Number

Mobile Telephone Number

Work Telephone Number

You must provide telephone numbers you can be contacted on to enable a registered nurse to contact you if you decide you would like to supply medical information over the telephone as explained on page 9.

5. Email Address

6. Date of Birth ☐☐/☐☐/☐☐☐☐

7. Country of Birth

8. If you were not born in the UK, how many years have you lived here? ☐☐

9. Are you currently moving home or proposing to change your address in the near future? Yes ☐ No ☐

(If 'yes' please provide your anticipated moving date and your new address)

Moving Date ☐☐/☐☐/☐☐☐☐

New Address

Postcode

10. Please provide the name and address of your usual Doctor

Name

Address

Postcode Telephone Number

B. Your occupation

References to 'occupation' mean the carrying on of a trade, profession, occupation, vocation or any other work from which you receive earnings.

1. What is your main occupation?

2. How long have you been employed in your main occupation? Years ☐☐ Months ☐☐

3. Do you have any other occupations? Yes ☐ No ☐

If 'yes' please provide details for each of your other occupations. Include any sports or hobbies for which you receive payment and include here what you get paid from these other activities or occupations.

4. Are you *(tick all that apply):*

Employed? ☐ Self Employed? ☐ In partnership with someone? ☐ A Company Director? ☐ Other? ☐

If a mix of employed and self-employed please provide details. If 'other' please provide details.

5. In your present occupation(s) will you be called upon to work outside the UK? Yes ☐ No ☐

If 'yes' please provide the following details.

Where?

For how long?

How often?

6. How many hours per week do you work?

a) in your main occupation?

b) in your other occupations overall? *(if applicable)*

7. How is your main occupation made up in terms of hours? Hours

Manual *(means physical, work done with your hands)*

Supervisory *(means giving instructions to others)*

Administrative *(means involved in paperwork)*

Other *(means anything not covered above)*

Total 100

8. How are your other occupations made up in terms of hours? Hours

Manual *(means physical, work done with your hands)*

Supervisory *(means giving instructions to others)*

Administrative *(means involved in paperwork)*

Other *(means anything not covered above)*

Total 100

If you have more than one other occupation please provide this information for each of your non-main occupations in the additional notes section on page 21.

9. Are you on a fixed term contract? *If solely self-employed please tick 'no'.* Yes ☐ No ☐

If 'yes' please give Contract start date ☐☐/☐☐/☐☐☐☐

Contract end date ☐☐/☐☐/☐☐☐☐

10. In the last two years have you had any time off work through illness or injury? Yes ☐ No ☐

(If 'yes' please complete the following)

Illness/Injury	Time off	Month	Year

(If you need more space please use page 21)

11. In the last 2 years have there been any occasions, other than for annual holiday leave or time off work through illness or injury, where you have not worked continuously in your main occupation? Yes ☐ No ☐

(If 'yes' please provide dates, length of time off and the reason below)

12. Are you currently off work, working reduced hours or had your duties altered due to sickness or injury? Yes ☐ No ☐

If 'yes' please give details but please note, if you are not currently working we are unable to consider your application.

13. Are you entitled to any earnings or Company sick pay if you are off work due to illness or injury? Yes ☐ No ☐

If 'yes' please specify amount and whether this would be paid weekly, monthly or as a lump sum £

For how long this would be paid

14. What were your earnings from your main occupation in the last 12 months?

Description	Earnings	Dividends	Total Earnings
Employed *Indicate your gross annual salary*	£	*Not applicable*	*Not applicable*
Self-employed/In Partnership *We require your taxable profit from your business* **not** *net profit* *i.e. What you tell HMRC in order that they may calculate your income tax payable*	£	*Not applicable*	*Not applicable*
Director in a private limited company, no more than three other shareholder directors 1. *Indicate your gross annual salary* 2. *Indicate your dividend payments from the company's regular business in the last 12 months*	£	£	£

15. What were your earnings from your other occupation(s) in the last 12 months? (if not provided in B3)

Description	Earnings	Dividends	Total Earnings
Employed *Indicate your gross annual salary*	£	*Not applicable*	*Not applicable*
Self-employed/In Partnership *We require your taxable profit from your business* **not** *net profit* *i.e. What you tell HMRC in order that they may calculate your income tax payable*	£	*Not applicable*	*Not applicable*
Director in a private limited company, no more than three other shareholder directors 1. *Indicate your gross annual salary* 2. *Indicate your dividend payments from the company's regular business in the last 12 months*	£	£	£

16. In the event of making a claim, will you be able to provide evidence that supports the earnings you have told us about in questions B14 and B15? *(see important information below)* Yes ☐ No ☐

If you select 'no' please tell us why not?

Important Information

In the event of a claim we will need to see original documentary evidence of your earnings in the 12 month period immediately before you became unable to work through your incapacity as we will use this period to calculate your benefit entitlement;

- If you are employed – we will require printed payslips, P60 and, if applicable your P11D.
- If you are self-employed or in partnership – we will require your most recent business accounts and latest agreed HM Revenue & Customs Tax Assessment.
- If you are employed as a Shareholder Director within a private limited company with not more than 3 other Shareholder Directors we will require evidence of the dividends you have received from your company's regular business, plus your printed payslips, P60 and, if applicable your P11D.
- If you select the Houseperson definition, we reserve the right to obtain, where relevant, proof of any income.

If you are unable to supply this information this will affect your entitlement in the event of claim

C. Other insurance

1. Have you had an application for life, disability, accident or critical illness insurance declined, postponed or made subject to non-standard terms? Yes ☐ No ☐

(If 'yes' please give the reason, type of cover, date (year) and terms of the offer)

2. Are you applying for cover elsewhere or do you have existing cover with another insurer which provides benefit for incapacity due to illness or injury? Yes ☐ No ☐

(If 'yes' give name of Insurer, type of insurance, amount of insurance)

Will this cover be cancelled? Yes ☐ No ☐

3. Have you made any claims on income protection, mortgage protection, payment protection, critical illness, waiver of premium, personal sickness and/or accident insurance contracts that you have currently or previously had? Yes ☐ No ☐

(If 'yes' please provide details with approximate dates (year), durations and reason for claim)

4. Will you continue this insurance after you have taken out a contract with us? Yes ☐ No ☐

5. Have you made any claims for compensation in relation to an injury, accident or any other condition? Yes ☐ No ☐

(If 'yes' please provide details with approximate dates, outcome and reason(s) for the claim(s))

D. Your protection needs

1. Have you received a **Key Features Document** for Income Assured Enhanced? Yes ☐ No ☐

Please refer to the Key Features Document before completing this section. If you have not received a Key Features Document please ask your Financial Adviser or the Society for a copy.

Have you received a **Key Information Document** for Income Assured Enhanced? Yes ☐ No ☐

Please refer to the Key Information Document before completing this section. If you have not received a Key Information Document please ask your Financial Adviser or the Society for a copy.

2. How many units of weekly cover do you require? ☐☐

Each unit of cover provides £10.50 per week in benefit. Fractions of units do not apply. A minimum of £52.50 and a maximum of £787.50 per week applies. This must not exceed 60% of the total earnings you state in Question B14 & B15 on page 6.

3. In the event of a claim when would you like benefit to be paid from?

After 1 week ☐ After 4 weeks ☐ After 8 weeks ☐ After 13 weeks ☐ After 26 weeks ☐ After 52 weeks ☐

4. At what age from 50 to 70 inclusive would you like cover to cease? ☐☐

5. For an additional premium would you like the option of building a capital sum? Yes ☐ No ☐

If you select this option you will share in surpluses and have the ability to build up a cash sum payable at the maturity of your contract

6. Which Incapacity Definition do you require?

(For full description of definitions please see the rules of the contract in Schedule 5 available from www.cirencester-friendly.co.uk)

Own throughout ☐

To qualify for benefit under this option you must, as a result of illness or accidental injury, be totally unable to perform your own occupation and must not be doing any other type of work.

Houseperson ☐

If you select this option, you must not be in paid employment but perform a vital role in maintaining the home and looking after the family to enable a partner to go out to work. In the event of illness or accidental injury, you must be confined to home or hospital and must be totally unable to perform the functions of a bona fide Houseperson. Regular benefit is limited to a maximum of £2,730 per annum.

7. Would you like your units of sick pay cover to increase with index linking? Yes ☐ No ☐

If you choose this option your units of cover and the premiums you pay will be automatically reviewed on 1st January each year. This option is not available to Housepersons.

8. When would you like your contract to commence?

As soon as possible ☐ Undecided ☐ Specified date ☐☐/☐☐/☐☐☐☐

9. When would you like your premium payments to be collected?

6th of the month ☐ 18th of the month ☐ *If no date is given payments will be taken on the 6th of the month.*

10. For a small additional premium you have the option of applying for the following 'My Extra Benefits' alongside your income protection contract;

Fracture & Hospitalisation Benefit ☐ and/or Immediate Death Benefit ☐

Please refer to the My Extra Benefits Key Facts Document. If you have not received a Key Facts Document please ask your Financial Adviser or the Society for a copy.

11. If you have selected the Immediate Death Benefit option, please complete the boxes below. Otherwise, we would be required to pay your estate. In the event of your marriage this nomination will be automatically revoked and you will need to complete a new Nomination Form.

I (FULL NAME)	
hereby nominate	
Of the address	

to receive the benefit payable at my death, under the rules of the Society.

E. Your health and lifestyle

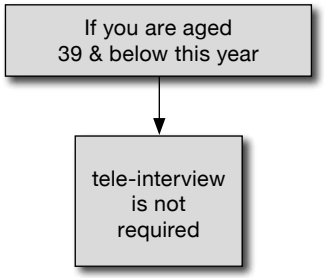
So that we can process your application without delay and offer you terms we need to gather medical information. We can do this a number of ways. You can **either** complete Section E of this form or give the information to a registered nurse over the telephone (a tele-interview).

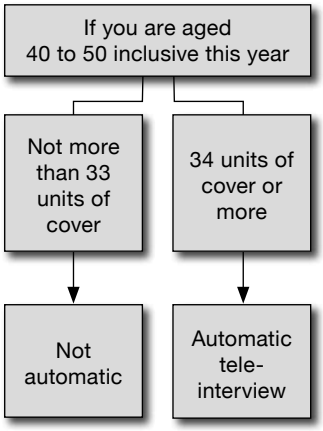
The following diagram will help to establish if a tele-interview will **normally apply.**

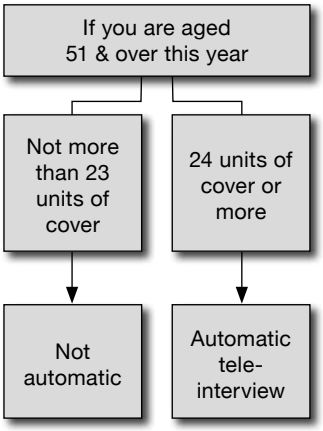
If a tele-interview applies you need not complete the medical questions in Section E. (Go to Section F)

HOWEVER:

If you **DO NOT** want to have a tele-interview, or one is not automatically required as above then you can simply complete Section E of this form.







Important Information

If the medical information you provide is incomplete or unclear then we may need to gather more information. A quick and convenient way to capture this information is over the telephone.

Would you be happy to provide any complete or missing information over the telephone? Yes ☐ No ☐

If you answer 'no' then we may ask you to complete questionnaires, additional information statements or we may write to your medical practitioner for a report if additional information is required.

When completing Section E if you answer 'yes' to a question but would prefer not to give details to your Financial Adviser you can send it direct to our Underwriting Department marked 'private and confidential'. Please also refer to the Access to Medical Reports Act and Data Protection Act on page 22 of this form.

If you are unclear about any of the questions we ask or the terms we use, our Underwriting Team will be happy to explain. When we talk of 'practitioners' this includes the like of doctors, health professionals, chiropractors, osteopaths, physiotherapists, acupuncturists, herbalists, chiropodists and counsellors. When we refer to 'treatment' we are talking of tablets (prescribed or over the counter), medicine, injections, inhalers, physiotherapy, prescribed exercise, acupuncture or cognitive behaviour therapy (CBT). If you are in any doubt speak to us by calling 01285 652492 ext 8300.

Please be aware that we will not necessarily write to your medical practitioner so you must make full disclosures on the application form.

1. What is your height and weight? *(Clothed without shoes)*
(Please measure and weigh yourself before completing this question)

Height ☐ ft ☐☐ ins or ☐☐☐ cms Weight ☐☐ st ☐☐ lbs or ☐☐☐ kgs

2. What is your typical weekly consumption of Alcohol ☐☐☐ units and Tobacco/Cigarettes ☐☐☐

1 pint standard lager/beer = 2 units, a 125ml (small) glass of wine =1.5 units, a 25ml measure of spirits = 1 unit.

3. At anytime have you been advised to reduce your consumption of alcohol or tobacco or received medical advice, counselling or treatment in connection with alcohol, tobacco or other drug abuse? Yes ☐ No ☐
(If 'yes' please provide the following details a) year b) by whom c) why?)

4. Do you use or have you used recreational drugs or drugs other than for prescribed purposes Yes ☐ No ☐
(If 'yes' please advise a) drug b) dates and durations used c) frequency of use)

5. Do you currently or have you any prospect or intention of engaging in hazardous activities? Yes ☐ No ☐
(e.g. Car or motorcycle racing, hang gliding, flying other than as a fare paying passenger etc)

If 'yes' please provide the following details:

What Hazardous Activity do you participate in?	
How often do you engage in this activity?	

At any time have you been injured as a result of the activity referred to above? Yes ☐ No ☐

Please use this space to provide details of the injury you suffered as a result of this activity:

Please complete the following tables to show whether you have had or received treatment, had tests, checkups or advice relating to the condition in each of the three time periods stated.

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
6. Bones, muscles, tendons, ligaments and cartilage. Have you had: a) Arthritis (including rheumatoid arthritis)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Gout?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
c) A diagnosis of osteoporosis / osteopenia?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
d) Fibromyalgia?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
e) Any disease, condition or disorder of the back, back pain or neck including sciatica and ankylosing spondylitis or any surgery to your neck, back or other joints?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
f) Repetitive strain injury or any other symptoms, including pain or limitations affecting the ligaments, bones, tendons, cartilage or muscles?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
g) Any disease, condition or disorder of the joint(s) including hip, shoulder, knee, wrist or any other joint?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
7. Blood. Have you had: Any condition, disorder, or abnormality of the blood including anaemia or abnormal blood test results?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and dates. 4. Time off work and when. 5. Whether blood results are now normal and if so from when.*
8. Blood Pressure. Have you had: High or low blood pressure?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Which condition. 2. Dates and durations. 3. Treatment, when commenced and whether still being taken. 4. Whether medication has been changed in the last 12 months and if so how. 5. Time off work and when. 6. Last reading if known.*
9. Bowel Have you had: a) Piles or haemorrhoids, coeliac disease, irritable bowel syndrome (IBS)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
b) Crohn's disease, ulcerative colitis or any other bowel condition(s)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
10. Broken Bones Have you had: A broken bone or fracture?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Dates. 2. Which bone (if applicable state right or left). 3. Whether a full recovery has been made. 4. Whether surgery carried out and whether metalwork still present or if removed, when.*
11. Cancer and Tumours Have you had: Cancer, leukaemia, Hodgkin's disease, lymphoma, spinal, acoustic or brain tumours (whether malignant or benign)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
12. Cholesterol. Have you had: Raised cholesterol?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Dates and durations. 2. Treatment, when commenced and whether still being taken. 3. Whether medication has been changed in the last 12 months and if so how. 4. Time off work and when. 5. Last reading if known.*
13. Circulation Have you had: a) Varicose veins, a single episode of deep vein thrombosis (DVT), poor circulation or chest pain?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
b) Stroke, mini-stroke, transient ischaemic attack (TIA) or a brain haemorrhage including subarachnoid haemorrhage?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
c) Any disease, condition or disorder of the arteries in the legs or of the aorta, such as varicose veins, more than one episode of deep vein thrombosis or thrombophlebitis (swelling of a vein caused by a clot)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
14. Depression/Anxiety Have you had: a) Depression, anxiety, stress, low mood, panic attacks, bereavement reaction, anger management, fatigue, insomnia or eating disorders?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Any condition which has required referral to a psychiatrist, psychologist or counsellor?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
15. Diabetes Do you have diabetes?	
Currently Yes ☐ No ☐	*1. Date diagnosed. 2. Treatment. 3. Time off work and when. 4. Latest HbA1c or IFCC result (and date). 5. Whether there have been complications such as eye, nerve, circulatory or kidney problems.*
16. Ears: Have you had: Any condition, disorder or abnormality of the ears including hearing loss, balance problems, tinnitus or infection of the inner ear (such as labyrinthitis)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
17. Eyes Have you had: Blurred or double vision, or any condition, disorder or abnormality of the eyes including glaucoma or cataract? (Sight problems corrected by glasses or contact lens can be ignored).	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
18. Fatigue: Have you had: Chronic fatigue syndrome (CFS), debility or ME?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
19. Head : Have you had: Blackouts, fainting, frequent headaches, migraines, dizziness or vertigo?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
20. Heart: Have you had: Any disease, condition, abnormality or disorder of the heart including heart attack, angina, heart valve disorder, irregular heartbeat, palpitations or heart enlargement?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
21. Hernia: Have you had: A hernia?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Where and the type/site (e.g. left side groin). 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
22. Kidneys and Bladder Have you had: Any disease, condition, disorder or abnormality of the kidney, bladder or urinary tract including blood or protein in the urine and urinary tract infections?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
23. Liver Have you had: Any disease, condition, disorder or abnormality of the liver including hepatitis?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
24. Nervous System (i) Have you had any: a) Disease of the central nervous system including multiple sclerosis (MS), optic neuritis or paralysis?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Numbness, change in skin sensation, muscle weakness or paralysis, tremor or difficulty with upper and/or lower limb co-ordination or walking?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
c) Epilepsy or fits?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
25. Nervous System (ii) Do you have: Parkinson's disease, cerebral palsy, Alzheimer's disease or dementia?	
Currently Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
26. Lung Disease Have you had: Sarcoidosis, tuberculosis, emphysema or chronic obstructive pulmonary disease?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
27. Non Cancerous Conditions Have you had: An internal or external lump, benign tumour, cyst, polyp or growth?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Which condition 2. Dates and durations. 3. Tests carried out, results and when. 4. Treatment and dates. 5. Time off work and when.*
28. Nose, Throat and Breathing Have you had: Asthma, hayfever, bronchitis, chest infection, nose or sinus problem(s), condition(s) or abnormality(ies)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
29. Sexually Transmitted Disease(s) Have you: Tested positive for HIV, Hepatitis B or C or a sexually transmitted disease or infection, or are you awaiting the result of such a test?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
30. Skin Have you had: Any disease, condition, abnormality or disorder of the skin including eczema, dermatitis, psoriasis or a mole or freckle which has bled, become painful or changed appearance?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
31. Stomach Have you had: Any disease, condition, abnormality or disorder of the digestive system, pancreas, gall bladder, indigestion/heartburn or stomach ulcer?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
32. Thyroid Have you had: Any disease, condition, abnormality or disorder of the thyroid including abnormal thyroid readings?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and dates. 4. Time off work and when. 5. Whether blood results now normal and if so from when.*
33. Urine Have you had: Sugar, protein or blood in your urine or ever been told your urine was not normal?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Which condition. 2. Dates and durations. 3. Treatment and dates. 4. Time off work and when. 5. Whether urine results now normal and if so from when.*
34. Female only Have you had: Painful or heavy periods, abnormal bleeding or any gynaecological (including abnormal cervical smear) for which you have sought advice or been given treatment or investigation or in the case of cervical smear been requested to attend for other than the routine 3 or 5 yearly smears?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
35. Male only Have you had: Any disease, condition, abnormality or disorder of the male reproductive system, a testicular disorder, prostate disorder or abnormalities including an abnormal PSA test?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 21 if necessary)*
36. Miscellaneous a) In the last 5 years have you had any medical attention with a doctor or other medical practitioner or at a hospital or required any investigation, scan or test including blood tests which you haven't already mentioned?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Symptoms. 2. Tests carried out. 3. Diagnosis. 4. Duration of problem. 5. Treatment and dates. 6. Time off work and when.*
b) Have you any expectation of seeking medical advice or treatment in the near future or have you been advised to have any medical investigation, test or scan or are you awaiting any results?	
Currently Yes ☐ No ☐	*1. Reason. 2. Symptoms. 3. Nature of test / advice to be sought or already sought. 4. Who consulted / to be consulted. 5. Dates.*
c) Do you have any medical condition(s) or injury(ies) which you haven't already mentioned for which you are taking tablets, medicines, prescribed drugs or any other treatment? For example physiotherapy or alternative therapies (contraceptives and cold/flu remedies can be ignored).	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Your family

Have any of your natural parents, brothers or sisters suffered from any of the following before the age of 65?

Condition		Whether you have been advised to have tests as a result of your relatives illness and if so the date, results and whether further tests are due or recommended.
Alzheimer's Disease		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Cancer – please state type below		
Yes ☐ No ☐	Type Age at onset Relative	Yes ☐ No ☐
Diabetes		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Heart Disease (including heart attack, angina, bypass, heart enlargement, cardiomyopathy) – please state which type below		
Yes ☐ No ☐	Type Age at onset Relative	Yes ☐ No ☐
Huntington's Disease		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Motor Neurone Disease		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Multiple Sclerosis		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Parkinson's Disease		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Polycystic Kidney Disease		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐
Stroke		
Yes ☐ No ☐	Age at onset Relative	Yes ☐ No ☐

F. Declarations and consents

Access to Medical Reports Act 1988

- I have read the explanation of my rights under the Access to Medical Reports Act 1988 (page 22) and consent to Cirencester Friendly Society Limited being provided with my medical information, including copies of my medical records, from any medical practitioner who has attended to me concerning anything which affects my physical or mental health or condition.
- I understand that Cirencester Friendly may ask for information from my Medical Practitioner as part of their random disclosure verification process to verify I have given accurate and complete information to Cirencester Friendly. My instruction above applies to those random requests as well and I understand that I will be notified in writing if my application is selected for that check.

If you wish to see the medical report before it is returned to us. Please tick here ☐

Data Protection

- I have read the explanation of the applicable Data Protection legislation (page 22) and I consent to the Society being provided with information from other insurers or third parties concerning my application including, but not limited to, information concerning my physical and/or mental health, previous or concurrent applications for life or health insurance and any relevant financial information.
- I authorise the release of confidential information, including but not limited to, information concerning my physical and/or mental health or condition obtained by the Society, to any doctors or specialists appointed by the Society in relation to the application and to any third party who requires such information for lawful purposes.
- If applicable, I understand a specially trained interviewer will contact me with regards to further medical information for my application for Income Assured Enhanced and I consent to this process.
- I consent to medical information being obtained by Cirencester Friendly from my Medical Practitioner under the random disclosure verification process if my application is selected for that check.

Contract Agreement

- **I have read and understood the important notes on page 3 of this application form.**
- I have read over the replies to all of the questions in this form and I accept full responsibility for the accuracy of the answers and statements given, even if they were recorded on my behalf and confirm that they are true and complete to the best of my knowledge and belief and I have disclosed all information material to my application. I consent to the Society undertaking any other enquiries they consider necessary concerning this application.
- I understand that the medical information from my Medical Practitioner under the random disclosure verification check (if this application is selected for that check) may be received after the start of the contract. I also understand that if I have not accurately and completely disclosed Cirencester Friendly shall advise me in writing of any changes to the contract and reserves the right to cancel the contract and end membership.
- I understand that the Memorandum and Rules along with the Schedule 5 to the Rules (available from www.cirencester-friendly.co.uk) constitute the contract between me and the Society and it is important for me to read these within 30 days of receipt. *(If there are any terms that you do not understand or do not wish to agree to please discuss it with us or your Financial Adviser before signing. Only sign this application if you wish to be bound by the terms and conditions).*
- I shall advise the Society in writing of any changes in my health and other circumstances (including financial) which happen before the contract commences.
- I hereby apply for Membership of the Society and agree to abide by the Society's Rules, present and future. I further agree that if I have made any incorrect statement in this, my application, the Rules of the Society will be strictly applied.

Due to the current Covid-19 pandemic, please also confirm the following are all true. Please tick here ☐

- I am working my full hours, on full occupational duties and am not in receipt of furlough payments or SEISS. I am also not aware that I am due to be furloughed, made redundant or that my work circumstances are due to change in any way but if they do, I will notify you.
- I am aware that at claim any Benefit payable will be subject to me providing evidence of my taxable earnings, for the 12 months immediately preceding the claim.

Please tick to confirm you have read and understood the following Exclusion, which means that no benefit will be paid in relation to; ☐

Coronavirus / Covid-19, other viral and respiratory tract infections, (to include self-quarantine, of all types, and / or caring for others with these conditions) and associated conditions including post viral fatigue and post viral depression, if you are applying for a 1 week deferred period.

Signature of Applicant

Date ☐☐/☐☐/☐☐☐☐

Print Full Name

(please use block capitals)

Please Note

The Applicant should not sign the above declaration unless the Application Form has been completed and checked by them for accuracy.

G. Additional information

Question No.

Important information

for all applicants which should be read carefully

Data Protection

- For the purpose of the applicable Data Protection legislation the Data Processor and Controller in relation to the information you supply is the Cirencester Friendly Society Limited. Any information about you will be put on our database and held in accordance with the Data Protection legislation.
- It will be used for the purposes of processing this application and administering your membership.
- We may conduct, or have conducted on our behalf, checks with external agents in connection with this application for validation purposes.
- We or our agents may ask you for more information, or carry out further checks and searches and/or share information with third parties when assessing your application, managing your membership or assessing any future claims for fraud prevention and verification.
- We may ask for information from your Medical Practitioner as part of our random disclosure verification process.
- We may share information about you with:-
  - Third parties – including but not limited to Trustees in Bankruptcy, reinsurers, underwriters, financial institutions, credit reference agencies and medical agencies (including UK and abroad) and sub-contractors and agents in order to provide you with the service applied for, for fraud prevention or so that services may be processed on our behalf.
  - Government regulators and the Ombudsman to help resolve a complaint or for audit purposes.
  - Other insurance companies who require the information for lawful purposes.
- If you ask, we will tell you what information we hold about you and provide information in line with the applicable Data Protection legislation. You should let us know if you think any information we hold about you is inaccurate, so we can correct it.
- On request from you we will forward you a copy of our Subject Access Request (SAR) forms for completion. You will be required to send the completed forms to us enclosing proof of ID and the specified fee. On receipt of completed and signed forms, your request will be processed and a response made within one calendar month from the date they are received. All SAR requests will be subject to legal restrictions placed on disclosure. Please direct enquiries relating to your data to The Data Protection Officer, Cirencester Friendly Society Limited, Mutuality House, The Mallards, South Cerney, Cirencester, Glos. GL7 5TQ.
- To help improve our service and in the interests of security we may monitor and/or record your telephone calls with us.
- **Notice** – Insurers and Friendly Societies pass information on claims concerning income protection insurance, critical illness insurance and waiver of premium benefits to the Income Protection Claims Register, run by the Association of British Insurers.
- The aim is to prevent fraudulent claims. When you make a claim, we may notify the register of that event.

Access to Medical Reports Act 1988

(or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991)

- Before we can apply for a medical report from a Medical Practitioner who has cared for you, we need your consent by signing the Declarations and Consents. (page 20) Therefore please read this section before you sign the Declaration as it sets out your rights under the Access to Medical Reports Act 1988 (or 1991 Order) and the procedure for dealing with reports.
- You do not have to give your consent but, if you do not, we may be unable to proceed with your application. If you do consent, you can also say whether you wish to see the report before it is sent to the Society.
- If you tell us you wish to see the report (we will tell you at the same time as we write to the Medical Practitioner and we will tell him/her you wish to see the report), you will then have 21 days to contact him/her about arrangements for you to see the report.
- If you tell us you do not wish to see the report, we do not have to notify you if we apply for one.
- Whether or not you tell us you wish to see the report before it is sent to us, the medical practitioner must let you see a copy for up to 6 months after it is supplied to us, if you ask the medical practitioner.
- If you ask the Medical Practitioner for a copy of the report, he/she can charge you a reasonable fee to cover his/her costs.
- If you have seen a report before it is sent to us, the medical practitioner cannot submit it until he/she has your consent.
- You can write to the Medical Practitioner, asking him/her to amend any part of the report which you consider to be incorrect or misleading and have attached to the report a statement of your views on any part where you and the medical practitioner are not in agreement and which he/she is not prepared to alter.
- The medical practitioner is not obliged to let you see any part of the report if, in his/her opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the medical practitioner‘s intentions towards you, or if disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you.
- In such cases, the Medical Practitioner must notify you and you will be limited to seeing any remaining part of the report.
- If it is the whole report which is affected, the Medical Practitioner must not send it to us unless you give your consent.

Cirencester Friendly

DIRECT Debit

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

Please fill in the whole form using a ball point pen and send it to:

Cirencester Friendly Society Limited
Mutuality House
The Mallards
South Cerney
Cirencester, Glos.
GL7 5TQ

Service user number

9	3	0	3	7	9

Name(s) of account holder(s)

Reference

Bank/Building Society account number

Branch sort code

Instruction to your bank or building society

Please pay (Cirencester Friendly Society Limited) 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 (Cirencester Friendly Society Limited) and, if so, details will be passed electronically to my bank/building society.

Name and full postal address of your bank or building society

To: The Manager — Bank/building society

Address

Postcode

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

DIRECT Debit

- 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 Cirencester Friendly Society Limited will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Cirencester Friendly Society Limited 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 Cirencester Friendly Society Limited 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 Cirencester Friendly Society Limited 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.

How to submit an application form

Scan & email:
newbusiness@cirencester-friendly.co.uk

Advisers, did you know you can apply online?
You can register and apply online at https://oa.cirencesterfriendly.co.uk/
alternatively, call our Sales Team to discuss your options on **0800 587 5098**.

Post:
Cirencester Friendly
Mutuality House
The Mallards
South Cerney
Cirencester
Glos.
GL7 5TQ

Income Assured Enhanced

Cirencester Friendly
Mutuality House
The Mallards
South Cerney
Cirencester
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Fax: 01285 641246
Email: info@cirencester-friendly.co.uk
Web: www.cirencester-friendly.co.uk

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