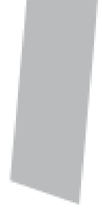
Alteration Form



NOTES

Please read these notes carefully before completing the application form.

Please make sure that you:

Use blue or black ink;

Use BLOCK CAPITALS throughout;

Correct and initial any alterations. Do not use correction fluid;

Complete all relevant sections as fully as possible;

Use a separate piece of paper if you need any more space for any of your answers but please sign and date it.

On your request, we will send you a copy of your application form and a copy of the relevant master terms and conditions.

All the questions on this application form will be considered by the specific Assurance Company in assessing the acceptability of your application. Please take reasonable care to answer all the questions honestly and to the best of your knowledge. If you don't a claim may be rejected or not fully paid or your policy may be cancelled. Please answer all questions as failure to do so will mean that your application may be delayed as we will have to contact you for the missing answers. Please do not assume that we will contact or obtain a report from your doctor.

It is very important that you tell us if there is a change to any of the following between completion of this Application Form and your Plan cover starting:

a) The Insured's personal health;
b) The Insured's family history;
c) The Insured's occupation;
d) The Insured's participation in any hazardous leisure activities;
e) The Insured's travel or residence;
f) The Insured's lifestyle (smoking/alcohol consumption/etc.)

If you do not, this may result in the non-payment of any claim or your Plan being cancelled.

Genetic Test Results

If this application, taken together with any other insurance policies you already have, is for life insurance up to a sum of £500,000 or critical illness up to £300,000 you need not disclose any genetic test you may have had.

You need not disclose the results of any genetic test undertaken in the context of research.

Genetic test results need only be disclosed where the sum exceeds either £500,000 for life insurance or £300,000 for critical illness and their use by insurers has been independently approved.

You may, of course, disclose any genetic test result, which is in your favour.

If you either have a family history of, or are experiencing symptoms of, or are having treatment for, a genetic condition, you must tell the Assurance Company.

Further information is available on request, which fully explains this Plan and details of the genetic tests approved for use by insurers.

PERSONAL DETAILS

Plan Number ☐ – ☐ – ☐ – ☐ – ☐ – ☐

Surname

Title

First Names

Current Address

It is essential that you enter your post code

Post Code

Telephone Number Day/W ork Evening/Home

Date of Birth ☐ ☐ – ☐ ☐ – ☐ ☐ ☐ ☐

National Insurance Number ☐ ☐ – ☐ ☐ – ☐ ☐ – ☐ ☐ – ☐

Marital Status

REVISED MORTGAGE DETAILS

New Mortgage Address *(if applicable)*

Post Code

PLAN REQUIREMENTS – Please confirm the full revised amount required

New Required ISA Maturity Value £ New Mortgage Amount £

Assumed Annual Growth Rate *(between 2% - 8%)* % Remaining Plan Term Years

The New Required ISA Maturity Value may equal your New Mortgage Amount or if there are dual applicants, may be half of the amount of the mortgage or another proportion. Please ensure the correct New Required ISA Maturity Value is disclosed as this will affect the amount of your Regular Subscriptions.

The New Mortgage Amount is the amount upon which any Mortgage Interest Payments are to be calculated.

Unless you specify otherwise a 5% annual growth rate will be used for your Assumed Annual Growth Rate. Please note that there is no guarantee that your chosen rate will result in the target maturity value being met, as the performance element of your Plan is not guaranteed. The projection rates used in the illustration do not represent any promise that your maturity value will be met.

REVISED PROTECTION BENEFITS – Please confirm the full revised amount required

These benefits will be provided by the associated Assurance Company.

Life Assurance and Critical Illness Benefits

Either A.
Life Assurance £
(which includes Terminal Illness Insurance)

Type of Benefit **Tick One Box Only**

Decreasing term plus the value of your ISA ☐ *(this provides the precise amount required on death) or*

Level term plus the value of your ISA ☐ *(this provides the value of your ISA in addition to the required insured amount)*

With optional
Additional Stand Alone Critical Illness Benefit: £
(which includes Total Permanent Disability Insurance)
This amount will be level and is payable in addition to any life assurance benefit and the value of your ISA.

or B.
Life Assurance or earlier Critical Illness Benefit: £
(which includes Terminal Illness and Total Permanent Disability Insurance)

REVISED PROTECTION BENEFITS (Continued) – Please confirm the full revised amount required

Type of Benefit	**Tick One Box Only**	
Decreasing term plus the value of your ISA	☐	*(this provides the precise amount required on death or earlier critical illness) or*
Level term plus the value of your ISA	☐	*(this provides the value of your ISA in addition to the required insured amount)*

With optional
Additional Stand Alone Critical Illness Benefit £ ______ *(which includes Total Permanent Disability Insurance) This amount will be level and is payable in addition to any life or earlier critical illness benefit and the value of your ISA.*

Long Term Sickness and Unemployment Benefit - Tick Yes or No as appropriate

Long Term Sickness Protection (sickness, accident or disability)

Plan Subscriptions	☐ Yes	☐ No
Mortgage Interest Payments	☐ Yes	☐ No

Plan Subscription Cover is for the amount of your Normal Regular Subscription to your Plan.
Mortgage Interest Payments Cover will be based on the New Mortgage Amount you have shown on page 1.

REVISED NORMAL REGULAR SUBSCRIPTION – Please confirm the revised contribution required

New Total Normal Regular Subscription £ ______

Complete only if a fixed premium is required. If left blank this will be calculated for you based upon the maturity value requested and the value of your Plan at the date the Plan is amended.

Preferred monthly day for direct debit collection ______ (1st - 28th day)

ALTERATION DATE DETAILS

(A) The Plan is to be amended immediately on acceptance ☐
(B) The Plan is to be amended upon receipt of confirmation from me / my agent ☐

If any benefit you apply for is not accepted at ordinary rates we will refer back to your financial adviser, irrespective of instructions given above. **Please note:** The commencement date cannot be backdated.

ADVICE DECLARATION

Have you received advice from a financial adviser in relation to the alterations you want to make on this plan?

☐ Yes ☐ No

Please continue overleaf.

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL.

THE INSURED'S PERSONAL DETAILS

1. Have you in the last 5 years or do you intend to:

(a) Participate in any sport or pastime which involves any additional risk of accident such as motor sports, mountaineering or underwater activities?

Yes ☐ No ☐

If **Yes**, please provide details.

(b) Travel or reside abroad (apart from holiday visits)?

Yes ☐ No ☐

If **Yes**, please provide details. Include countries visited, duration of visits and frequencies of visits.

(c) Fly (except as a fare-paying passenger on an established public service) or take part in aviation-related sports?

Yes ☐ No ☐

If **Yes**, please provide details.

(d) Do you serve in the Territorial Army or the Volunteer Reserves of the Armed Forces?

Yes ☐ No ☐

2. Do you have any other Synergy Plans?

Yes ☐ No ☐

If **Yes**, please provide the plan number(s).

3. Do you have or are you currently applying for any critical illness insurance cover with us or any other company? (excluding this application)

Yes ☐ No ☐

If **Yes**, please state the total sum assured you are or will be covered for:

£

4. Have you ever been declined (refused cover), deferred or offered non-standard terms for life cover, critical illness or any incapacity benefit?

Yes ☐ No ☐

If **Yes**, please provide more detail:

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL.

THE INSURED'S OCCUPATION DETAILS

1. What is your employment status?
   - Employed full time (16 hours or more each week)………….. ☐
   - Employed part time (less than 16 hours each week)……….. ☐
   - Self-employed…………………………………………………... ☐
   - House person…………………………………………………… ☐
   - Unemployed…………………………………………………….. ☐
   - Student…………………………………………………………… ☐
   - Retired…………………………………………………………… ☐

2. What is your Occupation? ☐

3. Do you work for any of the following?
   - HM Forces…………………………………………………… Yes ☐ No ☐
   - Fishing Industry………………………………………………... Yes ☐ No ☐
   - Oil and Gas Industry (Rig or offshore)……………………… Yes ☐ No ☐
   - Sports Professional…………………………………………… Yes ☐ No ☐
   - Licensed Trade………………………………………………… Yes ☐ No ☐
   - Entertainment………………………………………………….Yes ☐ No ☐

   If none of the above is applicable, please state the type of business / industry in which you work:

4. Does your occupation involve any form of manual or physical activity (including, but not limited to, lifting and carrying or the need to work on your feet for long periods)?
   Yes ☐ No ☐

   If **Yes,** please detail the main manual or physical tasks you do and specify the percentage of your day spent doing this task.

Task	**% of day**
Driving	
Lifting/Carrying	
Standing	
Other	

   If **other,** please state:

5. Does your occupation involve work at heights over 40ft (12.2 Metres)?
   Yes ☐ No ☐

   If **Yes**, please answer the following questions:

   (a) Average height you work at ft
   (b) Maximum height you work at ft
   (c) % of time working above 40 feet %

6. Does your occupation involve driving more than 18,000 miles per annum?
   Yes ☐ No ☐

7. Does your occupation involve working with any form of machinery or tools?
   Yes ☐ No ☐

   If **Yes**, please give full details:

Type of machinery or tool	% of the day

8. Does your job involve any of the following?
   a. Commercial Underwater Diving…... Yes ☐ No ☐
   b. Being Underground………………… Yes ☐ No ☐
   c. Handling Explosives……………….. Yes ☐ No ☐

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL.

THE INSURED'S HEALTH QUESTIONS

IMPORTANT NOTES:

(1) Please read all of the important customer notes on page 2 of this Alteration Form.

(2) If you prefer, you may complete the health questions in private and return them direct to our Chief Medical Officer (at the address on the back of this form). Please indicate on this form if you have done so.

1. What is your height and weight? You should give your exact measurements. If unsure of these please check.

* Delete as appropriate

Height ______ ft/m*

Weight ______ st/kg*

2a. What is your average consumption of alcohol units per week?

(1 unit = 1 single pub measure of spirits/small (125ml) glass of wine or 1/2 pint of standard strength beer, lager or cider)

______ Units

2b. Have you ever been advised to reduce or cut down your alcohol intake; or has your alcohol intake ever exceeded the recommended weekly amount of 14 units?

Yes ☐ No ☐

If Yes, please provide details.

3. Have you smoked or used any tobacco products in the past 12 months?

Yes ☐ No ☐

If Yes, please provide details of **daily** amounts:

Cigarettes	
Cigars	
Pipe - oz/grams	
Tobacco - oz/grams	
Nicotine replacement products	

IMPORTANT NOTE: We may carry out random tests to confirm the non-smoker status.

4. Have you ever used recreational drugs? This includes cannabis, ecstasy, cocaine, heroin or similar substances.

Yes ☐ No ☐

If Yes, please provide details, including types of drugs and dates of use.

THE INSURED'S HEALTH QUESTIONS CONT.

5a. Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Note, if the result is negative, the fact of having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.

Yes ☐ No ☐

5b. Within the last five years have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU).

Yes ☐ No ☐

5c. Within the last five years have you tested positive or been treated for any disease, which was transmitted sexually?

Yes ☐ No ☐

If you have answered **YES** to **5a, 5b or 5c** please give full details including the nature and date of tests, the reason for exposure, the countries involved (if applicable) and/or the nature of any sexually transmitted diseases. If you require more space please attach a signed and dated note to this application.

6. Do you currently have or have you ever had any of the following:

Question	Yes	No
(a) Cancer, leukaemia, hodgkin's disease, lymphoma, brain or spinal tumour?	Yes ☐	No ☐
(b) Heart disease or disorder – including heart attack, angina, heart murmur, cardiomyopathy, heart valve defect or heart surgery?	Yes ☐	No ☐
(c) Stroke or transient ischaemic attacks (mini-stroke), brain haemorrhage or permanent brain injury through accident?	Yes ☐	No ☐
(d) Multiple sclerosis, epilepsy, paralysis, muscular dystrophy, parkinson's disease (or other movement disorders), motor neurone disease or cerebral palsy?	Yes ☐	No ☐
(e) Disease or disorder of the arteries – including disease in the legs, deep vein thrombosis or the aorta?	Yes ☐	No ☐
(f) Diabetes or sugar in the urine?	Yes ☐	No ☐
(g) Mental illness that has required hospital treatment or referral to a psychiatrist or other specialist?	Yes ☐	No ☐

If you have answered '**Yes**' to any of question 6, please give the details below and on the following page.

Disease/disorders:

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL.

THE INSURED'S HEALTH QUESTIONS CONT.

Date of first symptoms:
Date of last symptoms:
Treatment:

Results of investigations:
Do you require a follow up review?
Are you fully recovered from the condition?
Time off work and when:

If you require more space please attach a signed and dated note to this application.

7. In the last 5 years have you had any of the following:

(a) A lump or growth of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size? Yes ☐ No ☐

(b) Chest pain, irregular heart beat, raised blood pressure or raised cholesterol? Yes ☐ No ☐

(c) Optic neuritis, numbness, tingling, facial pain, visual disturbance including blurred vision or double vision, dizziness, chronic fatigue or tiredness? Yes ☐ No ☐

(d) Seizure, fits, fainting or blackouts? Yes ☐ No ☐

(e) Any disorder of the digestive system, liver, stomach, pancreas, gall bladder or bowel – including gastric or duodenal ulcer, hepatitis, colitis or crohn's disease? Yes ☐ No ☐

(f) Any disorder of the kidneys, bladder or prostate – including blood or protein in the urine or urinary tract infections? Yes ☐ No ☐

(g) Blood disorder or anaemia? Yes ☐ No ☐

(h) Any disorder of the adrenal, pituitary or thyroid glands? Yes ☐ No ☐

(i) Any pain or other disease, disorder or problem relating to your back, neck, joints, bones or muscles including arthritis, slipped disc, rheumatism or gout? Yes ☐ No ☐

(j) Asthma, bronchitis or any other disorder of the lungs or respiratory system? Yes ☐ No ☐

THE INSURED'S HEALTH QUESTIONS CONT.

(k) Any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorder? Yes ☐ No ☐

(l) Disorder of the eyes including blindness or problems with sight? You can ignore sight problems fully corrected by glasses or contact lenses. Yes ☐ No ☐

(m) Disorder of the ears including difficulty hearing? Yes ☐ No ☐

(n) Any gynaecological disorder (including cervical smears) or breast condition for which you have been referred to a specialist or required investigations or treatment? Yes ☐ No ☐

(o) Any investigation, x-ray, scan or blood test for any condition not already mentioned (or been advised to have any of these)? Yes ☐ No ☐

(p) A surgical operation for any condition not already mentioned? Yes ☐ No ☐

(q) Any form of medical attention at a hospital as an inpatient or outpatient for any condition not already mentioned? Yes ☐ No ☐

If you have answered '**Yes**' to any of question 7, please give the details below.

Disease/disorders:

Date of first symptoms:

Date of last symptoms:

Treatment:

Results of investigations:

Do you require a follow up review?

Are you fully recovered from the condition?

Time off work and when:

If you require more space please attach a signed and dated note to this application.

THE INSURED'S HEALTH QUESTIONS CONT.

8. In the last 5 years have you been off work for 2 weeks or more for any medical condition, illness or injury? NOTE: You can exclude any medical conditions, illnesses or injuries already disclosed in this form.

Yes ☐ No ☐

If Yes, please provide details:

If you require more space please attach a signed and dated note to this application.

9a. Are you aware of any other medical condition or symptoms where you intend to seek medical advice or are you waiting for the results of any medical investigation?

Yes ☐ No ☐

If Yes, please provide details.

9b. Are you currently taking prescribed drugs, medicines, tablets or any other form of treatment for any condition not already mentioned (Oral contraceptives can be disregarded)?

If Yes, please provide details.

If you require more space please attach a signed and dated note to this application.

10. Before the age of 65, did either of your parents or any brothers or sisters, suffer or die from:

(a) Cancer?	Yes ☐	No ☐
(b) Heart disease, stroke or diabetes?	Yes ☐	No ☐
(c) Multiple sclerosis or alzheimer's disease?	Yes ☐	No ☐
(d) Muscular dystrophy, parkinson's disease, motor neurone disease or haemochromatosis?	Yes ☐	No ☐
(e) Huntington's disease, polycystic kidney disease or polyposis of the colon?	Yes ☐	No ☐
(f) Any other potentially hereditary disease or disorder?	Yes ☐	No ☐

If you have answered **Yes** to any of the above please provide full details on the next page.

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL.

THE INSURED'S HEALTH QUESTIONS CONT.

If you have answered **Yes** to any part of question 10, please complete this table.

Relationship			
Illness (if cancer, which body part was affected?)			
Age at diagnosis			
Current age			
Age at death (if applicable)			

If you require more space please attach a signed and dated note to this application.

THE INSURED'S DOCTORS DETAILS

Please provide details of your current doctor:

Name:

Address:

Postcode:

Telephone Number:

Please give details of your previous doctor if you have changed doctor in the last 6 months. See page 14 for consent to access personal files and medical reports.

Please provide details of you previous doctor:

Name:

Address:

Postcode:

Telephone Number:

ACCESS TO MEDICAL REPORTS CONSENT FORM

PLEASE DO NOT ASSUME THAT WE WILL WRITE TO YOUR DOCTOR. IT REMAINS YOUR REPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY.

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

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent 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 keep 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 the 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 think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health
- Any care, medication or treatment you are currently receiving
- The results of referrals or tests you are waiting for
- Any time off work in the last three years
- Your past health
- Details (excluding minor self-limiting conditions/ailments) 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; or
  - 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, urinalysis (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.

We have asked your doctor 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; or
- predictive genetic test results.

The information you and your doctor provide about your health may result in us:

- refusing to provide insurance;
- increasing premiums above standard rates; and/or restricting the policy conditions; or
- setting premiums at standard rates; or
- setting exclusions or postponing cover.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to:

The Senior Underwriter, Synergy Financial Products Limited, PO Box 1010, St Albans, Herts, AL1 9NB

DECLARATION to the Assurance Company

I declare that I have taken reasonable care to answer the questions honestly and to the best of my knowledge. I understand that a claim may not be paid in full or may be rejected or my policy may be cancelled if I have not. I consent to the associated Assurance Company seeking medical information from any insurance office to which an application has been made for insurance on my life and I authorise the giving of such information.

I undertake to notify the Assurance Company in writing of any change in my medical or other circumstances between the date of completing this proposal and the date the Plan cover begins and I agree to accept the usual form of Certificate and to be bound by the Master Terms and Conditions.

I have read the notes describing my rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and I consent to The Associated Assurance Company seeking information from any doctor who has attended me concerning my physical or mental health.

I wish to see the report before it is sent to the Assurance Company (Please tick): ☐

Unless I have ticked the box above I confirm that I do not wish to see the report before it is sent to the Assurance Company. I am aware that I may approach my doctor with a request to see a copy of the report within 6 months of its completion. I apply for the insurances indicated above and agree to be bound by my Plan Terms and Conditions.

NOTE: Submission of a completed application form does not imply commencement of the protection risk. A letter of acceptance from Synergy Financial Products Limited on behalf of the Assurance Company will indicate the insurance risk is acceptable. Please take reasonable care to answer all the questions honestly and to the best of your knowledge. If you don't a claim may be rejected of not fully paid or your policy may be cancelled. Please answer all questions as failure to do so will mean that your application may be delayed as we will have to contract you for the missing answers. Please do not assume that we will contact or obtain a report from your doctor.

DATA PROTECTION ACT

Synergy Financial Products Limited is a data controller within the meaning of the Data Protection Act 2018. You hereby consent to such use by Synergy Financial Products Limited of the personal information given under this contract as may be reasonably necessary in providing services to you and in updating our customer records. You are entitled to have access to the data we hold about you and are entitled to have your personal data rectified or erased. Please refer to our privacy policy on our website address below to read more about your rights.

Note: Your signature embraces all of the relevant declarations and authorises the above.

Signature

Date

Please note that a copy of the Master Terms and Conditions on which the insurance will be made is available on request, and that a copy of this completed proposal form will also be available on request.