Synergy Protect

Your Personal Protection Plan

Alteration Form

Advice Details

Have you received advice in relation to this alteration? ☐ Yes ☐ No

If you have ticked yes, please complete the broker details below.

Broker Name	Company Name	Network	Agency Number	Commission Requirement

NOTES

Please read these notes carefully before completing the application form

Please make sure that you:

Use black or blue 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 of 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 of £300,000 for critical illness and their use by insurers had 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

If two people are applying each Applicant will be issued with a Synergy Protect Plan of their own. And each plan will use a separate Direct Debit.

	First/Single Applicant	Second Applicant
	Each Applicant should complete or tick the boxes as necessary	
Title		
Surname		
First Names		
Current Address		
Post Code		
It is essential that the Post Code is included.		
Telephone Number Day/Work		
Evening/Home		
Date of Birth	☐☐ – ☐☐ – ☐☐☐☐	☐☐ – ☐☐ – ☐☐☐☐

We will need to see your Birth Certificate, and, if you are a married woman, your Marriage Certificate to authenticate these details before a claim can be paid.

Sex	**Male** ☐ **Female** ☐	**Male** ☐ **Female** ☐
Marital Status		

For example, single, married, divorced, separated, widowed, co-habiting

Where applicable, what is the Second Applicant's Relationship to the First Applicant?

For example, Husband, Wife, Partner, Co-Habiting

Personal details *(continued)*

Dual plan

Where the Second Applicant details have been completed two plans will be issued, one to each applicant. Each plan will use a separate direct debit instruction. A claim made by one of the applicants would typically be paid into the estate of that applicant and not directly to the other applicant.

Discount allowed for cases submitted at the same time as shown on the illustration.

Mortgage details

	First/Single Applicant	Second Applicant
	Each Applicant should complete or tick the boxes as necessary	
Is the Plan being effected in conjunction with or to relate to a mortgage?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
If no - you are not required to complete the rest of this section (please go to page 4).		
If yes -		
Amount of Mortgage	£ _____	£ _____
Mortgage Term The Plan Term on page 7 will be the same as the Mortgage Term	_____ Years	_____ Years
Type of Mortgage **Interest Only**	☐ **Yes**	☐ **Yes**
Capital and Interest	☐ **Yes**	☐ **Yes**

All correspondence will be sent to your address shown on page 2 until your Plan commences and direct debit collections begin.

Correspondence will continue to be sent to that address unless you have notified us of the address of the property being mortgaged in the section below. In such circumstances, correspondence will then be sent to that new address. Any change of address should, of course, be notified to us.

If possible please complete this section but it is not mandatory.

If this section is not completed, we will use your address on page 2 until you notify us otherwise.

Address of Property being Mortgaged _____

_____ **Post Code** _____

If the address of a new property is not known, then please advise us of it as soon as possible.

Mortgage Lender's Name _____

Branch _____ **Address** _____

_____ **Post Code** _____

Mortgage Account Number
(if known) _____

Insurance cover

The Insurance Cover will be provided by The Prudential Assurance Company Limited, except for Unemployment Insurance, which will be provided by Hamilton Insurance Company Limited.

Life and Critical Illness Insurance

You may, if you wish, choose to select any one, two or all three of the following (subject to the requirements outlined below):

A Life and Terminal Illness Insurance
B Stand Alone Critical Illness Insurance
C Combined Life with Critical Illness Insurance

Each choice may have a different Sum Insured and each Sum Insured may be on a level or decreasing cover basis.

However, you must select at least £10,000 of Insurance under Option A or Option C. If you wish, the sum of Option A and Option C can equal £10,000 (a minimum of £5,000 of each). The minimum Insurance under Option B is £10,000. If Option B or C is selected, Children's Critical Illness Cover may also be chosen.

Please complete your personal requirements. (You can increase, decrease, amend, add and/or remove Insurance from the Plan at any time subject to underwriting requirements).

The Plan Term for all Insurance will be as shown on page 7.

	First/Single Applicant	Second Applicant
	Each Applicant should complete or tick the boxes as necessary	
A **Life and Terminal Illness Insurance**	**£** _____	**£** _____
Type of Cover	☐ **Level Cover**	☐ **Level Cover**
	☐ **Decreasing Cover***	☐ **Decreasing Cover***
B **Stand Alone Critical Illness Insurance (which includes Terminal Illness and Total Permanent Disability Insurance)**	**£** _____	**£** _____
Type of Cover	☐ **Level Cover**	☐ **Level Cover**
	☐ **Decreasing Cover***	☐ **Decreasing Cover***
C **Combined Life with Critical Illness Insurance (which includes Terminal Illness and Total Permanent Disability Insurance)**	**£** _____	**£** _____
Type of Cover	☐ **Level Cover**	☐ **Level Cover**
	☐ **Decreasing Cover***	☐ **Decreasing Cover***

*Decreasing Cover means that the Cover selected decreases each year such that the amount payable is intended to equal the amount outstanding on a Repayment Mortgage equal to the initial Sum Insured selected taken out for the Plan Term.

Children's Critical Illness Insurance

Children's Critical Illness Insurance, which is level cover, can only be selected if the Applicant has also chosen Stand Alone Critical Illness Insurance (Option B) and/or Combined Life with Critical Illness Insurance (Option C).
Children's Critical Illness Insurance can be added later, for example, on the Birth or Adoption of a Child.

Do you require Children's Critical Illness Insurance? ☐ **Yes**

Children's Critical Illness Insurance will continue until the Review Date following the youngest child attaining age 18. Either Applicant can add Children's Critical Illness Insurance to the Plan. The maximum Sum Insured on one Child's life is £25,000 or 50% of the Applicant's Critical Illness Insurance whichever the less. If both Applicants choose Children's Critical Illness Insurance, the maximum claim value in respect of one Child is £25,000. Each child will be covered between the age of 1 and the Review Date following attaining age 18.

Date of Birth of Youngest Child ☐☐–☐☐–☐☐☐☐

Please specify the total amount of Children's Critical Illness Insurance needed. Minimum £5,000, Maximum £25,000 **£**_____ **(A)**

If the Plan is effected on a dual application basis, please specify the required split of total Children's Critical Illness Insurance for the first and second applicant **£**_____ **(B)** **£**_____ **(C)**

The total of box B and box C should equal the amount entered in box A.

Sickness and Accident Insurance

You may, if you wish, choose to select any one, or both of the following.

A Plan Subscription Cover / Waiver of Premium,
B Specific Cover / Income Replacement

Please complete your personal requirements. (You can increase, decrease, amend, add and/or remove Insurance from the Plan at any time subject to Underwriting requirements).

	First/Single Applicant	Second Applicant
	Each Applicant should tick Yes as appropriate and complete or tick the other boxes as necessary	
A Plan Subscription Cover / Waiver of Premium	☐ **Yes**	☐ **Yes**
Plan Subscription Cover is for the amount of the Subscription to your Plan. In the event of a claim, the amount payable will match the Subscription due from time to time under the Plan.		
B Specific Cover / Income Replacement	☐ **Yes**	☐ **Yes**
Please specify the required monthly cover	**£_____per month**	**£_____per month**

In the event of a claim, the total benefit payable (excluding any Plan Subscription Cover) under all Sickness, Accident and Disability Benefit Plans (from this Plan and any others with other Providers) will not exceed 55% of your average monthly gross earnings in the 12 months prior to the commencement of disability. This restriction applies irrespective of the amount of Cover paid for. Special rules apply if you are not working or are receiving continuing income at the time disability commences, please see the Plan Terms and Conditions. The maximum claim period is dependent on your selection under "Payment Period".

	WEEKS	WEEKS
Deferred Period	☐ **4** ☐ **13** ☐ **26**	☐ **4** ☐ **13** ☐ **26**

Please indicate your choice of Deferred Period. The earliest date that payment can commence is 4 weeks from the date of cause of the claim which must meet the definition of disability applicable.

Occupation Classes 3 and 4 may not choose a 4 week deferred period. Examples of occupation classes are as follows:-

Occupation Class 1: Administrative/Clerical, Solicitor, Accountant
Occupation Class 2: General Practitioner, Shop Assistant, Pharmacist
Occupation Class 3: Domestic Electrician, Teacher, Waitress
Occupation Class 4: HGV Driver, Builder, Police Officer

Maximum Payment Period	**2 years** ☐	☐ **2 years**
	or	or
	Term Expiration or to age 65 if earlier ☐	☐ **Term Expiration or to age 65 if earlier**

In the event of a claim, depending on the selection made, benefits will either be paid for a maximum period of 2 years OR until the expiration of the Plan Term (or to age 65 if earlier). Payment of benefit is subject to the Applicant continuing to meet the definition of disability applicable and the requirements of The Prudential Assurance Company Limited.

Guaranteed Insurability Option

This cover will be provided by The Prudential Assurance Company Limited.

Guaranteed Insurability Option (Maximum age at entry is 40 years old next birthday)	☐ **Yes**	**Yes**

The option applies to Life and Terminal Illness Insurance, Stand Alone Critical Illness Insurance, Combined Life with Critical Illness Insurance and Sickness and Accident Insurance.

The option covers House Purchase (or House Improvements) and Family Options (Birth/Adoption of a Child and Marriage).

	First/Single Applicant	Second Applicant
	Each Applicant should complete as necessary	
Plan Term	_____**Years**	_____**Years**
The minimum term of the Plan is 10 years. The maximum term of the Plan is 40 years or until the Applicant's 70th Birthday whichever is the shorter period. However, once the Plan is operative, insurance can be increased, decreased, amended, added and/or removed even when the outstanding term is less than 10 years in accordance with the Plan Terms and Conditions.		
Regular Monthly Subscription *Please insert the amount from your Illustration. If possible, please attach a copy of the Illustration for each Applicant to this Application Form.* Please see the Important Note below concerning the first Subscription payable and the calculation of age next birthday at commencement of the Plan. This may affect your choice of a preferred day for Direct Debit collection.	**£**_____	**£** _____
Please specify your preferred monthly day for Direct Debit collection	_____**1-28th day**	_____**1-28th day**

Please note, should you choose a preferred direct debit date, which effectively makes the first direct debit date due after your birthday, the premium calculation will be based on the preferred date making you a year older. This may increase your premium.

You may each choose separate collection dates for each Plan irrespective of whether a Dual Plan is selected. Two direct debit instructions will be required in all cases where two Applicants are involved. This maintains personal independence.

The first direct debit will be collected 14 days after your Plan commences and you will be informed in writing of the date the next direct debit will be made. This will be on your preferred direct debit collection day but the second direct debit will not be made until at least a month has elapsed since the Plan Commencement Date. If a date is not specified, the collection date will be on the monthly anniversary of the date your Plan commences or on the first of the month if your Plan commenced on the 29th, 30th or 31st of a month.

Important note:

At commencement of the Plan the first direct debit collected may include a proportionate Subscription in respect of the period of risk from the Plan Commencement Date to the first preferred monthly collection date after the Plan Commencement Date (known as the Preferred Date).

Commencement date

	First/Single Applicant	Second Applicant
	Each applicant should complete or tick the boxes as necessary	
Please tick the box if you wish the plan to start immediately	☐	☐

If you do not wish it to start immediately, it will be delayed until you or your intermediary tell us to start it. Direct Debit collections will not begin until the plan starts.

Notes:

(i) If any insurance you apply for is not accepted on standard terms we will refer back to you or your intermediary

(ii) The commencement date cannot be backdated.

The insured's personal details

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

First/Single Insured	Second Insured

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?

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐
If **Yes**, please provide details.		If **Yes**, please provide details.	

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

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐
If **Yes**, please provide details. Include countries visited, duration of visits and frequencies of visits.		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?

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐
If **Yes**, please provide details.		If **Yes**, please provide details.	

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

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐

2. Do you have any other Synergy Plans?

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐
If **Yes**, please provide the plan number(s).		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)

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐
If **Yes**, please state the total sum assured you are or will be covered for - **£**		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?

First/Single Insured		Second Insured	
Yes ☐	No ☐	Yes ☐	No ☐
If **Yes**, please provide details.		If **Yes**, please provide details.	

The insured's occupation details

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

First/Single Insured **Second Insured**

1. What is your employment status?

	First/Single Insured	Second Insured
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?

	First/Single Insured		Second Insured	
HM Forces……	Yes ☐	No ☐	Yes ☐	No ☐
Fishing Industry……...	Yes ☐	No ☐	Yes ☐	No ☐
Oil and Gas Industry (Rig or offshore)……	Yes ☐	No ☐	Yes ☐	No ☐
Sports Professional……	Yes ☐	No ☐	Yes ☐	No ☐
Licensed Trade……	Yes ☐	No ☐	Yes ☐	No ☐
Entertainment……	Yes ☐	No	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)

First/Single Insured: Yes ☐ No ☐ Second Insured: 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	Task	% of day
Driving		Driving	
Lifting/Carrying		Lifting/Carrying	
Standing		Standing	
Other		Other	

If **other,** please state: _____ _____

5. Does your occupation involve work at heights over 40ft (12.2 Metres)?

First/Single Insured: Yes ☐ No ☐ Second Insured: Yes ☐ No ☐

If **Yes**, please answer the following questions (delete ft/m as appropriate):

	First/Single Insured	Second Insured
(a) Average height you work at	ft/m	ft/m
(b) Maximum height you work at	ft/m	ft/m
(c) % of time working above 40 feet	%	%

6. Does your occupation involve driving more than 18,000 miles per annum?

First/Single Insured: Yes ☐ No ☐ Second Insured: Yes ☐ No ☐

7. Does your occupation involve working with any form of machinery or tools?

First/Single Insured: Yes ☐ No ☐ Second Insured: Yes ☐ No ☐

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

Type of machinery or tool	% of the day	Type of machinery or tool	% of the day

8. Does your job involve any of the following:

	First/Single Insured		Second Insured	
a. Commercial Underwater Diving…...	Yes ☐	No ☐	Yes ☐	No ☐
b. Being Underground……	Yes ☐	No ☐	Yes ☐	No ☐
c. Handling Explosives……...	Yes ☐	No ☐	Yes ☐	No ☐

The insured's health questions

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

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.

	First/Single Insured	Second Insured

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*	ft/m*
Weight	st/kg*	st/kg*

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

(1 unit = 1 single measure of spirits/small (125ml) glass of wine or ½ pint of standard strength beer, lager or cider)

Units	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 amounts of 14 units?

Yes ☐ No ☐	Yes ☐ No ☐
If **Yes**, please provide details.	If **Yes**, please provide details.

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

Yes ☐ No ☐	Yes ☐ No ☐
If **Yes**, please provide details of daily amounts: Cigarettes_____ Cigars_____ Pipe – oz/grams _____ Tobacco – oz/grams_____ Nicotine replacement products_____	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 non-smoker status

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

Yes ☐ No ☐	Yes ☐ No ☐
If **Yes**, please provide details, including types of drugs and dates of use:	If **Yes**, please provide details, including types of drugs and dates of use:

The insured's health questions - continued

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

First/Single Insured **Second Insured**

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 ☐ 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 ☐ Yes ☐ No ☐

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

Yes ☐ No ☐ 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:

(a) Cancer, leukaemia, hodgkin's disease, lymphoma, brain or spinal tumour?

Yes ☐ No ☐ Yes ☐ No ☐

(b) Heart disease or disorder – including heart attack, angina, heart murmur, cardiomyopathy, heart valve defect or heart surgery?

Yes ☐ No ☐ Yes ☐ No ☐

(c) Stroke or transient ischaemic attacks (mini-stroke), brain haemorrhage or permanent brain injury through accident?

Yes ☐ No ☐ Yes ☐ No ☐

(d) Multiple sclerosis, epilepsy, paralysis, muscular dystrophy, parkinson's disease (or other movement disorders), motor neurone disease or cerebral palsy?

Yes ☐ No ☐ Yes ☐ No ☐

(e) Disease or disorder of the arteries – including disease in the legs, deep vein thrombosis or the aorta?

Yes ☐ No ☐ Yes ☐ No ☐

(f) Diabetes or sugar in the urine?

Yes ☐ No ☐ Yes ☐ No ☐

(g) Mental illness that has required hospital treatment or referral to a psychiatrist or other specialist?

Yes ☐ No ☐ Yes ☐ No ☐

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

First/Single Insured Disease/disorders:	**Second Insured Disease/disorders:**

The insured's health questions - continued

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

Date of first symptoms:	Date of first symptoms:
Date of last symptoms:	Date of last symptoms:
Treatment:	Treatment:
Results of investigations:	Results of investigations:
Do you require a follow up review?	Do you require a follow up review?
Are you fully recovered from the condition?	Are you fully recovered from the condition?
Time off work and when:	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 insize?
Yes ☐ No ☐ Yes ☐ No ☐

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

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

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

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

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

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

The insured's health questions - continued

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

(j) Asthma, bronchitis or any other disorder of the lungs or respiratory system?

Yes ☐ No ☐ Yes ☐ No ☐

(k) Any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorder?

Yes ☐ No ☐ 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 ☐ Yes ☐ No ☐

(m) Disorder of the ears including difficulty hearing?

Yes ☐ No ☐ 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 ☐ 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 ☐ Yes ☐ No ☐

(p) A surgical operation for any condition not already mentioned?

Yes ☐ No ☐ Yes ☐ No ☐

(q) Any form of medical attention at a hospital as an inpatient or outpatient for any condition not already mentioned?

Yes ☐ No ☐ Yes ☐ No ☐

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

First/Single Insured	**Second Insured**
Disease/disorders:	Disease/disorders:
Date of first symptoms:	Date of first symptoms:
Date of last symptoms:	Date of last symptoms:
Treatment:	Treatment:
Results of investigations:	Results of investigations:
Do you require a follow up review?	Do you require a follow up review?
Are you fully recovered from the condition?	Are you fully recovered from the condition?
Time off work and when:	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 - continued

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

First/Single Insured **Second Insured**

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 ☐ Yes ☐ No ☐

If **Yes**, please provide details	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 ☐ Yes ☐ No ☐

If **Yes**, please provide details	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)?

Yes ☐ No ☐ Yes ☐ No ☐

If **Yes**, please provide details	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 ☐	Yes ☐	No ☐
(b)	Heart disease, stroke or Diabetes?	Yes ☐	No ☐	Yes ☐	No ☐
(c)	Multiple sclerosis or Alzheimers disease	Yes ☐	No ☐	Yes ☐	No ☐
(d)	Muscular dystrophy, Parkinsons disease, motor neurone disease or haemochromatosis?	Yes ☐	No ☐	Yes ☐	No ☐
(e)	Huntingdons disease, Polycystic kidney disease or Polyposis of the colon?	Yes ☐	No ☐	Yes ☐	No ☐
(f)	Any other potentially hereditary disease or disorder?	Yes ☐	No ☐	Yes ☐	No ☐

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

The insured's health questions - continued

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

First/Single Insured – If you have answered Yes to any part of the question 10, please complete this table.

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

Second Insured – If you have answered YES to any part of question 10, please complete this table.

Relationship			
Illness (if cancer, which part of the body 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 doctor's details

First/Single Insured – please provide details of your current doctor.

Name		(previous doctor)
Address		
Postcode		
Telephone number		

Please give details of your previous doctor if you have changed doctor in the last 6 months. See page 18 for consent to access personal files and medical reports.

Second Insured – please provide details of your current doctor

Name		(previous doctor)
Address		
Postcode		
Telephone number		

Please give details of your previous doctor if you have changed doctor in the last 6 months. See page 17 for consent to access personal files and medical reports.

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 Prudential Assurance Company Limited

I understand that this application is subject to written acceptance by The Prudential Assurance Company Limited ('Prudential') at its Customer Services Office.

I agree to Prudential obtaining medical evidence from any doctor who I have consulted about my physical or mental health in order to assess my application. Prudential may obtain relevant information from other insurers about previous or concurrent applications for Life, Critical Illness, Sickness, Disability, Accident or Private Medical Insurance for which I have applied. I authorise those asked for such information to provide it on production of this consent. This consent allows Prudential to obtain medical reports at any time during the life of the contract or after my death to support any claim made on the proceeds.

I agree that a copy of this agreement/consent given in this Declaration will have the validity of the

original. I agree to Prudential accepting medical reports faxed directly from my Doctor's surgery.

First Applicant/Single Applicant: I do not* object to copies of the report being faxed to any other company that I have applied to at their request.

Second Applicant: I do not* object to copies of the report being faxed to any other company that I have applied to at their

request. (*Delete the word 'not' if you do not want us to fax information).

I will inform Prudential immediately of any changes that occur before the policy starts. I understand that failure to do so may mean that a claim may not be paid.

By signing this Declaration, I am allowing Prudential to process my application using the information I have provided. This information can also be used to process any claim made on this policy.

If a paramedical screening or a medical examination is required, it will be necessary for us to share some of the information contained in the Application with another company authorised by us. The authorised company will contact you directly to make arrangements for the screening or examination to take place. By signing this declaration, I authorise Prudential to share this information.

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, or in Northern Ireland, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, as explained in this document.

I consent, without prejudice to my rights under the Act (the Order in Northern Ireland), to the doctor forwarding a report of the medical information to Prudential.

I agree that this consent shall not be invalidated by my death.

First/Single Applicant
I do not* wish to see the report in respect of the assurance applied for before it is sent to Prudential.

Second Applicant
I do not* wish to see the report in respect of the assurance applied for before it is sent to Prudential.

(*Delete the word 'not if' if you wish to see the medical report before it is sent to Prudential. If you do not see the medical report before it is sent to Prudential you still retain the right to see a copy of the report for a six-month period).

By submitting this application form to us, you consent to our processing sensitive personal data about you where this is necessary or appropriate. 'Sensitive' personal data may include, for example, information relating to your medical history, which we will use for underwriting and assessment purposes. You consent to the transfer of your information to countries, which may not provide an adequate level of data protection where this is necessary for any of the purposes referred to above. If we make such a transfer we will ensure your information is protected.

I apply for the insurances indicated above and agree to be bound by the Terms and Conditions of the Synergy Protect Plan.

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 website address below to read more about your rights.

Declaration to Synergy Financial Products Limited

I hereby apply for insurance under the Synergy Protect Plan administered by Synergy Financial Products Limited under the terms and conditions of the Synergy Protect Plan.

I understand that insurance under the Synergy Protect Plan is provided by The Prudential Assurance Company Limited and that Synergy Financial Products Limited administers the Plan.

Application Signature(s) in respect of the declarations to Prudential Assurance Company Limited and Synergy Financial Products Limited

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. My signature below applies to each of the applicable declarations contained in this application.

I have read and understood the Synergy Protect Plan Terms and Conditions and accept the terms under which Insurance that I have selected will be provided to me.

Signature of First/Single Applicant

Date: _____

_____

Signature of Second Applicant

_____

Date: _____

Under these regulations, there is a legal requirement to prove the identity of people who wish to enter into a financial contract. You may, therefore, be asked for some evidence of your identity. This will normally be a passport or similar form of identity check with additional proof of address from a gas bill, electricity bill or similar.

Instruction to your Bank/Building Society to pay Direct Debits

First applicant

Please complete parts 1 to5, the unshaded areas, to instruct your Bank/ Building Society to make payments directly from your account

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

1 Full name and postal address of your Bank/Building Society:

The Manager:

Postcode

2 Name(s) of Account Holder(s):

Originators Identification Number 8 4 0 4 3 3

Originators Reference (leave blank) /04

3 Sort Code - -

4 Account No.

5 Instruction to your Bank/Building Society and signature(s)
Please pay SFP Limited Direct Debits from the account detailed on this instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with SFP Limited and, if so, details will be passed electronically to my Bank/Building Society

Signature Date

Signature Date

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

Instruction to your Bank/Building Society to pay Direct Debits

Second applicant

Please complete parts 1 to5, the unshaded areas, to instruct your Bank/ Building Society to make payments directly from your account

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

1 Full name and postal address of your Bank/Building Society:

The Manager:

Postcode

2 Name(s) of Account Holder(s):

Originators Identification Number 8 4 0 4 3 3

Originators Reference (leave blank) /04

3 Sort Code - -

4 Account No.

5 Instruction to your Bank/Building Society and signature(s)
Please pay SFP Limited Direct Debits from the account detailed on this instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with SFP Limited and, if so, details will be passed electronically to my Bank/Building Society

Signature Date

Signature Date

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

Direct Debits

DIRECT DEBIT INSTRUCTION – The Direct Debit Guarantee

This guarantee should be detached and retained by the payer.

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, Synergy Financial Products Limited will notify you at least 14 days in advance of your account being debited or as otherwise agreed.

If an error is made by Synergy Financial Products 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 Synergy Financial Products Limited.

NOTE: One mandate must be completed for each applicant

Instruction to your Bank/Building Society to pay Direct Debits

Synergy Protect is issued and administered by Synergy Financial Products Limited.

Synergy Financial Products Limited
PO Box 1010
St Albans
AL1 9NB

Client Services & New Business
Telephone: 0330 123 9938
Facsimile: 01727 737819

E-mail: support@sfpl.co.uk

sfpl.co.uk

Registered address: Centrium 1, Griffiths Way, St Albans, AL1 2RD.
Registered in England Number: 179230. Authorised and regulated by
the Financial Conduct Authority. FCA Registration Number 312416.