wp|property|finance
Finance Made Easy

PROTECTION
Data Capture Form

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All applicants should complete the form thoroughly, answering all questions. If not applicable write NA, don't leave any boxes blank. If you answer YES to any question provide details and relevant dates. Use notes section if you need more space referring to the section applicable.

Failure to disclose relevant information could result in non-payment of a claim.

Financial Services and Markets Act 2000

Independent Financial Advisers and mortgage brokers are required to have proper regard for a client's best interests in any advice given. They must therefore do their utmost to ensure that they are aware of your financial circumstances so that their advice is the most suitable for your needs. The questions here have been specifically designed to help your adviser provide advice that meets your needs. If, for any reason, you decline to answer any, or all the questions or, if you fail to provide true and accurate information to the best of your knowledge, the advice given subsequently may not be best advice, as it can only be based on the information provided in this document.

Date completed		Completed by	

Applicants' details

	Applicant 1	Applicant 2
Name		
Date of birth		
Contact no.		
Are you applying for	Single cover ☐	Joint cover 1st event ☐ / Joint cover 2nd event ☐
Monthly affordable budget		

Section1. Existing Cover

	Applicant 1	Applicant 2
Please provide details of existing cover		
If any applicant has ever had an application for life, critical illness, or income protection cover which has been turned down or accepted on special terms, e.g. an increased premium or exclusion, provide name of the provider, date, and details of the decision:		

Section 2. Pastimes

	Applicant 1	Applicant 2
If you intend to take part in any potentially dangerous or hazardous sports or activities such as mountaineering, diving, private flying, motor etc. please provide details and regularity.		

Section 3. Lifestyle Questions

Your height: ft. Ins / cms		
Your weight: st. lbs / kilos		
Waist/dress size: ins. / cms		
If you are smoker of have you have used nicotine products or e-cigarettes, please provide details i.e. number of cigarettes/ cigars per day, pipe smoker amount, or other nicotine usage: **Random test may be carried out to verify smoking status**		
How many units of alcohol do you drink per week		

1 pint of beer = 3 units of alcohol. 1 glass of wine = 1.5 units of alcohol. 1 measure of spirits = 1 unit of alcohol.

If you have been advised by your doctor or other medical practitioner to drink less alcohol, please provide details and dates of your consultations		
If you have ever taken any recreational drugs, e.g. cannabis, ecstasy, heroin, cocaine, or any prescription drugs not prescribed by your doctor, please provide details and dates of the events:		
If, during the last 5 years you have lived or travelled abroad, other than for holidays for up to 30 days per year, please provide details and dates of the countries visited and duration of your stay:		
Do you intend to travel or work outside the UK?	Yes ☐ No ☐	Yes ☐ No ☐

Section 4. Doctor/Practice Details

Please provide the name or your GP or Practice. Please note we may not necessarily contact your doctor but even if we do, we still need you to disclose all material facts of your medical history. If you have been registered with your current GP or Practice for less than 6 months, please provide previous doctors details in the notes section

	Applicant 1	Applicant 2
Doctor or Practice name		
Time registered with them		
Address of GP or Practice		
Telephone contact no.		

Section 5. Main Medical Summary

If you answer 'yes' to any question, please give full details, i.e. symptoms or diagnosis of condition, dates, and duration, who was consulted, details and results of any tests and whether or not a full recovery was made. Please note that for those conditions indicated with an asterisk additional question will be required. Please do not assume that we will contact your doctor and that your doctor will provide the information we need. It remains your responsibility to complete this application form fully.

Do you have, or have you ever had any of the following? if yes, tick the box and provide an explanation	Applicant 1	Applicant 2
Any form of cancer, leukaemia, Hodgkin's disease, spinal tumour, lymphoma, or melanoma?	☐	☐
Heart disorder including heart attack, angina, cardiomyopathy, or heart murmur?	☐	☐
Stroke, brain haemorrhage, transient ischaemic attack (TIA), brain injury or brain tumour?	☐	☐
Multiple sclerosis, Parkinson's disease, paralysis, Alzheimer's disease, dementia or cerebral palsy?	☐	☐
Numbness, loss of feeling, tingling, tremor or temporary loss of muscle power?	☐	☐
Blindness, blurred/disturbed vision not fully corrected by glasses or contact lenses, e.g. optic neuritis or glaucoma?	☐	☐
Diabetes or sugar in the urine? *	☐	☐
Mental illness that has required hospital treatment or referral to a psychiatrist? *	☐	☐

Section 6. Medical History

In the last 5 years, have you had any of the following? if yes, tick the box and provide an explanation.

	Applicant 1	Applicant 2
Lumps, growth of any kind, any mole, freckle that has bled, become painful, changed colour, or increased in size? *	☐	☐
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol?	☐	☐
Asthma? *	☐	☐
Breathlessness, bronchitis, sarcoidosis, or any lung disease other than asthma? *	☐	☐
Epilepsy, dizziness, or blackouts? *	☐	☐
Deafness or any ear problem? *	☐	☐
Arthritis, or any muscle, bone, or joint disorder (e.g. sciatica, back, neck, shoulder or knee pain, RSI or gout?) *	☐	☐
Disorder of the digestive system, liver, stomach, pancreas, or bowel including ulcers, hepatitis, colitis, or Crohn's disease? *	☐	☐
Blood disorder or anaemia?	☐	☐
Thyroid disorder? *	☐	☐
Any kidney, bladder, or other Genito-urinary disorder, including blood or protein in the urine, kidney cysts or multiple urinary tract infections? *	☐	☐
Stress, anxiety, depression, insomnia, chronic fatigue or any psychiatric or eating disorder? *	☐	☐

Any skin disorder or allergy? *

(Females only) Abnormal cervical smear or mammogram, or had a biopsy of the breast cervix or uterus? *

(Males only) Prostate enlargement or raised PSA (prostate specific antigen)?

Had or have been advised to have any medical investigations, scans, or blood tests?

Have you received any form of medical attention at a hospital as an in-patient or out-patient?

Section 7. General Health Questions

Are you currently experiencing any symptoms or disorder for which you have not consulted a doctor?

Are you currently taking any drugs, medicines or tablets or receiving any other treatment for a condition not already mentioned?

Are you currently awaiting a medical consultation or hospital appointment, or awaiting the results of any tests?

Have you ever tested positive for HIV, hepatitis B or C or are you awaiting the results of a test?
(If the result is negative, the fact that you have had an HIV test will not affect your application for insurance)

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

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

Have you had more than 15 days sick leave in the last two years?

Section 8. Covid Questions

Have you had a positive Covid test? and if so, please provide the date ☐ ☐

Have you been asked to self-isolate? ☐ ☐

Have you been in contact with someone who has had, or does have Covid? ☐ ☐

Section 9. Family History

Have any of your parents, brother or sisters ever had any of the following medical conditions before they reached the age of 60?

If you are unable to answer this section due to being adopted or similar circumstances, please indicate in the notes below and explain the reasons why you are unable to answer in the space(s) below.

Alzheimer's disease	Yes ☐	No ☐
cancer	Yes ☐	No ☐
haemochromatosis	Yes ☐	No ☐
Heart Disease (including cardiomyopathy, heart attack or angina)	Yes ☐	No ☐
Huntington's disease	Yes ☐	No ☐
Kidney failure or polycystic kidney disease	Yes ☐	No ☐
Motor neurone disease	Yes ☐	No ☐
Multiple sclerosis	Yes ☐	No ☐
Parkinson's disease	Yes ☐	No ☐
Polyposis of the colon	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Any hereditary disorder	Yes ☐	No ☐

Notes: Reasons why you unable to answer the above or any additional information you feel is relevant:

Section 10. Bank Account Details

	Applicant 1	Applicant 2
Bank name		
Account name		
Account no. & sort code		
Telephone contact no.		
Use this account for direct debit instruction	Yes ☐ No ☐	Yes ☐ No ☐

By using this account for the direct debit instruction, you confirm the applicant is the account holder and the only person required to authorise Direct Debits on the account.

Notes & Further Medical Information

Please use this section to provide any further relevant information in relation to any question/s asked in this form.