Scottish Provident

Declaration of Health

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

Plan number(s)

Changes of circumstances

It is very important that you tell us if there is a change to your personal health, your family's medical history, any occupation change, participation in hazardous pursuits, travel or residence – between completing this declaration of health form and your cover starting, being reinstated or altered. If you do not do this, and this affects our assessment of risk, your insurance may be void.

Important information

- You can ask us for copies of the product guide, the policy benefit cover sheet, the policy benefit schedule, the standard provisions, critical illness definitions guide, the completed declaration of health form and the ABI Genetic Testing Code of Practice.

- We will use the information you give to us on this form to assess the insurance risk. You must fill in the form fully and truthfully to the best of your knowledge and belief. **If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application. Please note that any new information, not provided when you applied, that comes to light at claim stage (even if it is unconnected to the condition that you are claiming for) could mean your plan will not pay out.**

- In line with the ABI's policy on genetics and insurance, you do not need to tell us about any predictive genetic test result you have had unless you are applying for insurance which, when added to any existing insurance policies you have, exceeds the following limits:

  – £500,000 of death cover,
  – £300,000 of critical illness or death or earlier critical illness or
  – £30,000 each year for disability income benefit.

If you are applying for insurance which exceeds these limits, when combined with any of your existing insurance policies, you need to tell us in this declaration of health form about any predictive genetic test results you have had for Huntington's disease. If you have had any genetic test and feel that the result may be in your favour then you may inform us of this if you wish.

If you would like this information in large print, in braille or on cassette or CD, please call 0345 271 0900.

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How to fill in this form – Please use BLOCK CAPITALS throughout. Please use a BLACK ballpoint pen. Please use a separate piece of paper if you need any more space for any of your answers.

1 Personal details of life or lives to be assured

	First life	Second life
Title (Mr/Mrs/Miss/Ms/Dr or other)		
Sex (please tick)	☐ Male ☐ Female	☐ Male ☐ Female
Surname		
Forenames (in full)		

If the lives assured are also the owners we will use the address for the first life assured for all correspondence, unless advised otherwise.

Address		
Postcode		
Daytime telephone		
Evening telephone		
Mobile telephone		
E-mail address		
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y
What is your country of habitual residence?		

Your 'habitual residence' is where you have your main home address and bank account.

Country of nationality?		
Country of dual nationality?		
Were you born outside the UK, Channel Islands or the Isle of Man?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, have you been resident in the UK, Channel Islands or Isle of Man for **less than** 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, how long have you been resident in the UK, Channel Islands or Isle of Man?		
In the last 24 months have you been outside the UK, Channel Islands or Isle of Man for more than 30 consecutive days?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, which country/countries?		
For how long?		
Marital status	☐ Single ☐ Separated ☐ Divorced ☐ Married/ Civil partnership ☐ Widow(er) ☐ Partner	☐ Single ☐ Separated ☐ Divorced ☐ Married/ Civil partnership ☐ Widow(er) ☐ Partner

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2 Height and weight

It is very important that you provide accurate height and weight readings in these boxes. If you are in any doubt, please measure and weigh yourself now before completing this section.

	First life	Second life
What is your height?	ft/in **or** m/cm	ft/in **or** m/cm
What is your weight?	st/lbs **or** kg	st/lbs **or** kg
In the last 6 months has your weight **decreased** by more than 3kg/7lbs, through non-diet loss?	**Yes** **No**	**Yes** **No**
If yes, please supply details (please advise how much weight over what period of time and was there any known reason)		

3 Name and address of your doctor

Please give details of your previous doctor in the additional information section on page 7 if you have changed doctor in the last 6 months. See page 16 for consent to access to personal files and medical reports.

	First life	Second life
Name of doctor or practice		
Address/postcode		
Telephone number		

4 Occupation details

	First life	Second life
What is your occupation? (please tell us your exact job title or state whether unemployed or retired)		

Sometimes your job title may not clearly describe the type of work you do. If this is the case, it will help us to process your application if you give us a full description of your job. If you need more space, please use the additional information section on page 7.

Job description		
The industry in which you work		
Are you employed or self-employed?		
How many hours do you usually work each week?		

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

4 Occupation details (continued)

	First life	Second life
Are you a member of the Armed Forces, TA or reservists?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please advise Rank		
Are you under orders or on standby to serve abroad or in any area of conflict?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please supply full details		
Are you involved in any hazardous activities, for example, aviation, diving, parachuting, bomb disposal or special service groups?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details		
Have you been advised that any part of your unit, wing, crew or military equivalent is under orders or on standby for any troubled area?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details		
Does your occupation involve manual work, driving or working at heights?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please advise the percentage of your working day. **If some of these activities do not apply to you, please state NIL in the box provided**. Failure to give details of your activities may result in us not being able to pay a claim. If you want a second occupation to be covered under disability income benefit, please provide full occupational details in the additional information section on page 7.	% **Manual work**	% **Manual work**
	% **Driving**	% **Driving**
	% **Working at heights**	% **Working at heights**
	Typical height (ft/m)	**Typical height** (ft/m)

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

5 Smoking

	First life	Second life
Have you used any tobacco products in the last 12 months? If no, we may ask for a simple medical test to confirm this.	☐ Yes ☐ No	☐ Yes ☐ No
If yes, state your average WEEKLY usage:	Cigarettes:	Cigarettes:
	Cigars:	Cigars:
	Grammes of pipe tobacco:	Grammes of pipe tobacco:
If no, have you ever smoked?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, when did you stop?		

6 Alcohol

	First life	Second life
Do you drink, or have you ever drunk, more than 35 units of alcohol per week on a regular basis? One unit is defined as 1/2 pint of beer, or 1 glass of wine (125ml), or 1 measure (25ml) of spirits.	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details.		
Have you ever been given, or sought, advice from any medical practitioner in relation to your consumption of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details.		

7 Travel and pursuits

Please answer the following questions in as much detail as possible.
In some circumstances we may have to contact you for further information.

	First life	Second life
a) Have you any intention of travelling abroad (other than for holidays of less than 30 consecutive days)?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details.		
b) Have you any intention to participate in any hazardous sport or leisure activity? Hazardous pursuits could include, for example, aviation, caving/potholing, climbing, diving, horseriding, motorsports, mountaineering or yachting.	☐ Yes ☐ No	☐ Yes ☐ No
c) What is the activity you participate in?		
d) Do you participate in an amateur or professional basis?		
e) How long have you been involved in this?		

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

7 Travel and pursuits (continued)

	First life	Second life
f) How often do you participate per year (hours or events)?		
g) Will this increase in the future?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details		
h) Are you a member of a professional organisation or do you hold approved qualifications (for example, SMC, PADI etc)		
i) Please give maximum heights, depths or other extremes involved		
j) Do you participate in any racing, record attempts or any other competitive or specialist events?		
k) Do you, or do you intend to receive sponsorship or participate in activity outside the UK?		
l) Have you ever suffered any injury as a result of this activity?		

Please complete the following additional sections if relevant to you.

Motor Sport		
a) What type of vehicle do you use (include engine capacity)?		
b) What categories/formula do you compete in?		
c) What type of licence do you hold?		
Diving		
a) In which locations do you dive? (for example, lakes, rivers, caves, wrecks)		
b) Do you ever dive alone?	☐ Yes ☐ No	☐ Yes ☐ No
c) When was your last medical exam and what was the result?		
Aviation		
a) What type of aircraft do you fly as a pilot?		
b) How many hours each year do you fly as a pilot?		
c) How many hours each year do you fly as a passenger?		
d) Are all flights between licensed airfields?	☐ Yes ☐ No	☐ Yes ☐ No
e) Do you have any additional qualifications? (for example, night rating, instructor, IMC)		

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

7 Travel and pursuits (continued)

Climbing or mountaineering

	First life	Second life
a) Which best describes your activity – hillwalking, rock climbing or mountaineering?		
b) To which level do you participate? (Easy, moderate, difficult, very difficult, severe, very severe, hard very severe, extremely severe)		
c) How many climbs do you undertake each year?		
d) Where do you climb? (for example, UK, Europe, other)		

8 Previous proposals

	First life	Second life
Have you ever had an application for life insurance, critical illness cover or income protection insurance on your life refused, postponed or accepted on special terms by any insurance company?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please give dates and names of insurers:		

9 Additional information

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

10 Underwriting questions

Questions 1-5 should be completed for all lives assured.

If you answer "yes" to any of these questions, please give full details and answer all of the additional parts of the question below. If you wish to retain confidentiality, you can send your answers to: The Chief Medical Officer, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB. If you need more space, then please use the underwriting additional information section on page 14. We will rely on the information you give us, and you should not assume we will clarify or confirm with your doctor any facts that you give us.

We will use the information you give us on this form to assess the insurance risk. You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void.

Question 1 Do you currently have or have you ever had any of the following:	**First life**		**Second life**	
a) Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
b) Heart disease – including angina, heart attack or any other disorder of the heart?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
c) Stroke, brain haemorrhage, permanent brain injury through accident?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
d) Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
e) Any disorder of the central nervous system (the brain, spinal cord and nerves), not already mentioned? (This could include, for example, Huntington's disease, motor neurone disease or myelitis).	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
f) Disease or disorder of the arteries (including disease in the legs or of the aorta)? (This could include, for example, blockage or narrowing of an artery, intermittent claudication or inflammation of an artery).	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
g) Diabetes or sugar in the urine?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
h) Mental illness that has required hospital treatment or referral to a psychiatrist?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

If you have answered **NO** to all of the above then please proceed to Underwriting Question 2

What is the exact diagnosis of the medical condition?				
When did symptoms of this condition first occur?	Month:	Year:	Month:	Year:
When did you last have symptoms?	Month:	Year:	Month:	Year:
Do you have recurrent symptoms? If so, please state how many episodes or attacks of symptoms you have had since onset of the condition.				
Please describe the nature and severity of the symptoms.				

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

10 Underwriting questions
(continued)

Questions 1-5 should be completed for all lives assured.

	First life	Second life
Do they restrict you in any way?		
Have you seen a specialist for the condition? If so, please give their name and hospital.		
What medical investigations have been performed?		
What were the results, if known?		
Have all investigations now been completed?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Are you waiting for any follow-ups or reviews?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
When did you last see your doctor with this condition?	Month: Year:	Month: Year:
How many times have you been admitted to hospital for this condition and when was the last time?	Number of admissions: Month: Year:	Number of admissions: Month: Year:
When was the last time you went to hospital as an outpatient for investigations or check-up for this condition?	Month: Year:	Month: Year:
What treatment has been prescribed? Is it continuing?		
How much time off work have you had to take and when was this?		
Is any operation planned or being considered? If so, when?		

Question 2 Whether or not you have consulted a doctor, do you currently have, or in the last five years have you had, any of the following:

a)	A lump, a growth of any kind or any mole or freckle that has bled, become painful, changed colour or increased in size?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
b)	Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
c)	Asthma, bronchitis or any other respiratory disorder?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
d)	Numbness, loss of feeling, tingling or temporary loss of muscle power?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
e)	Seizure, fits, fainting or blackouts?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
f)	Any disorder of the eyes including blurred or double vision, optic or retro bulbar neuritis (you can ignore sight problems corrected by glasses or contact lenses)?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

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10 Underwriting questions
(continued)

Questions 1-5 should be completed for all lives assured.

		First life		Second life	
g)	Any disorder of the ears?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
h)	Arthritis, spine, neck or joint disorder (including slipped disc, back or neck pain or gout)?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
i)	Any disorder of the digestive system, liver, stomach, pancreas or bowel (including gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease)?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
j)	Any blood disorder or anaemia?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
k)	Any thyroid disorder?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
l)	Any kidney, bladder or any other disorder of the genito-urinary system (including blood or protein in the urine and urinary tract infections)?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
m)	Any kind of medical attention for depression, anxiety, stress, nervous breakdown or chronic fatigue?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
n)	Any investigation, scan or test not already mentioned? (This could include, for example, smear tests and other tests performed at your doctor's clinic).	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
o)	Any form of medical attention at a hospital as an inpatient or an outpatient?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
p)	A surgical operation?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

If you have answered **NO** to all of the above then please proceed to Underwriting Question 3

	First life	Second life
What is the exact diagnosis of the medical condition?		
When did symptoms of this condition first occur?	Month: Year:	Month: Year:
When did you last have symptoms?	Month: Year:	Month: Year:
Do you have recurrent symptoms? If so, please state how many episodes or attacks of symptoms you have had since onset of the condition.		
Please describe the nature and severity of the symptoms.		
Do they restrict you in any way?		
Have you seen a specialist for the condition? If so, please give their name and hospital.		

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10 Underwriting questions
(continued)

Questions 1-5 should be completed for all lives assured.

	First life	Second life
What medical investigations have been performed?		
What were the results if known?		
Have all investigations now been completed? Are you waiting for any follow-ups or reviews?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
When did you last see your doctor with this condition?	Month: Year:	Month: Year:
How many times have you been admitted to hospital for this condition and when was the last time?	Number of admissions: Month: Year:	Number of admissions: Month: Year:
When was the last time you went to hospital as an outpatient for investigations or check-up for this condition?	Month: Year:	Month: Year:
What treatment has been prescribed? Is it continuing?		
How much time off work have you had to take and when was this?		
Is any operation planned or being considered? If so, when?		

Question 3

a) Have you ever tested positive for HIV, hepatitis B or C or are you awaiting the result 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.)	☐ Yes ☐ No	☐ Yes ☐ No
If you have answered yes, please specify:		
Tested positive for HIV or hepatitis.	☐ Yes ☐ No	☐ Yes ☐ No
Awaiting HIV or hepatitis test result.	☐ Yes ☐ No	☐ Yes ☐ No
b) Within the last five years, have you been exposed to the risk of HIV infection? (Note: The risk can arise through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU.)	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details.		
c) Within the last five years, have you tested positive or been treated for any disease that was sexually transmitted?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details.		
d) Have you ever injected non-prescription drugs or have you ever taken drugs other than on medical advice?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details.		

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10 Underwriting questions
(continued)

Questions 1-5 should be completed for all lives assured.

	First life		Second life	
Question 4				
a) Are you due to have any check-up in the next 12 months in connection with any medical condition, or are you waiting for the result of any medical investigation?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
b) Are you currently taking prescribed drugs, medicines, tablets or any other treatment?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
c) Have you any expectation of seeking medical advice or treatment in the near future?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

If you have answered **NO** to all of the above then please proceed to Underwriting Question 5

What is the exact diagnosis of the medical condition?				
When did symptoms of this condition first occur?	Month:	Year:	Month:	Year:
When did you last have symptoms?	Month:	Year:	Month:	Year:
Do you have recurrent symptoms? If so, please state how many episodes or attacks of symptoms you have had since onset of the condition.				
Please describe the nature and severity of the symptoms.				
Do they restrict you in any way?				
Have you seen a specialist for the condition? If so, please give their name and hospital				
What medical investigations have been performed?				
What were the results if known?				
Have all investigations now been completed?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

10 Underwriting questions
(continued)

Questions 1-5 should be completed for all lives assured.

	First life	**Second life**
Are you waiting for any follow-ups or reviews?		
When did you last see your doctor with this condition?	Month: Year:	Month: Year:
How many times have you been admitted to hospital for this condition and when was the last time?	Number of admissions: Month: Year:	Number of admissions: Month: Year:
When was the last time you went to hospital as an outpatient for investigations or check-up for this condition?	Month: Year:	Month: Year:
What treatment has been prescribed? Is it continuing?		
How much time off work have you had to take and when was this?		
Is any operation planned or being considered? If so, when?		

Question 5 Have any of your parents, brothers or sisters ever had any of the following medical conditions before they reached age 60?	**First life**	**Second life**
Heart disease or disorder **Stroke** **Diabetes** **Cancer** **Multiple sclerosis** **Bowel disease or disorder** **Kidney disease or disorder** **Huntington's disease** **Alzheimer's disease** **Parkinson's disease** **Muscular dystrophy** **Motor neurone disease**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
	Relationship:	Relationship:
If yes, please state the diagnosis or cause of death (if cancer, please also state the type or site), the age at diagnosis or the age at death if applicable, for each relative.	Diagnosis or cause of death:	Diagnosis or cause of death:
	Age at diagnosis:	Age at diagnosis:
	Age at death (if applicable):	Age at death (if applicable):

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the form.

11 Underwriting additional information

12 Important notes

Scottish Provident is a division of the Royal London Group which consists of The Royal London Mutual Insurance Society Ltd and its subsidiaries.

We may need to share the information in this form with our agent for the purposes of requesting medical information or arranging examinations.

If you are applying for insurance with other companies at the same time as this, by signing the declaration you are agreeing to copies of any medical reports prepared on your behalf being shared between Scottish Provident and these other companies. If, however, another company asks us to provide copies of highly sensitive information (for example HIV test results), we will ask for your written permission before we do so.

We may ask you to contact your doctor if we are waiting for reports we have asked for.

You can ask us for a copy of the product guide, the policy benefit cover sheet, the policy benefit schedule, the standard provisions, critical illness definitions guide or your declaration of health form at any time.

The cover will not start, be reinstated or altered until we have assessed and accepted your declaration of health, and we have received a cheque or Direct Debit mandate.

If you are resident in:

- the UK your plan will be governed by the law of Scotland, except for unemployment benefit which is governed by the law of England;
- the Channel Islands or Isle of Man your plan will be governed by the law of England and held under Seal;

unless otherwise agreed with Scottish Provident.

If you have applied for unemployment benefit and premium payment benefit (unemployment), your contract for those benefits will be provided by UK General Insurance Ltd on behalf of UK General Insurance (Ireland) Ltd for whom Scottish Provident acts as agent.

You can ask us for details of general reassurance principles or details of any company we use to assess your application, by writing to us at: New Business Department, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.

13 Data protection statement

How we use your personal information
We, the Royal London Group (including Scottish Provident), may obtain personal information either from you directly, or with your consent, from your approved intermediary or from other sources such as your doctor or an identity authentication agency.

We will use your personal information (including sensitive personal information) for the following purposes:

- Providing and developing our products and services
- Improving customer care
- Verifying your identity and fraud prevention
- Research and analysis
- Marketing
- Legal and regulatory reasons
- Administering your plan.

We will retain your personal information for a reasonable period and we may also share information about you (in the UK and abroad) with other companies within the Royal London Group, your approved intermediary, our service providers and agents and with third parties such as auditors, underwriters, reinsurers, medical agencies, identity authentication and fraud prevention agencies, other financial institutions and legal and regulatory bodies.

Your personal data may be processed in countries outside the European Economic Area. This processing will be carried out by experienced and reputable organisations and only on terms which safeguard the security of your data and comply with the requirements of the Data Protection Act 1998.

We may contact you by mail, phone, fax, email or other electronic messaging either directly or through your approved intermediary with further offers, promotions and information about our products and services that may be of interest to you. By providing us with this information you consent to being contacted by these methods for these purposes.

☐ Please tick this box if you do not wish to receive these communications.

We may carry out an identity authentication check to verify your identity. This involves checking the details you supply against those held on any databases that may be accessed by the reputable third party company which carries out our checks. This includes information from the Electoral Register and fraud prevention agencies.

We will use scoring methods to verify your identity. A record of this search will be kept and may be used to help other companies verify your identity.

We may also pass information to financial and other organisations involved in money laundering and fraud prevention to protect ourselves and our customers from theft and fraud. If you give us false or inaccurate information and we suspect fraud, we will record this and share this information with other organisations.

We may monitor and record phone calls and retain these for the purposes of training and quality assurance and to ensure that we have an accurate record of your instructions.

If you provide us with information about another person, you confirm that they have appointed you to act for them to consent to the processing of their personal data and that you have informed them of our identity and the purposes (as set out above) for which their personal data (including sensitive personal data) will be processed.

You have the right to ask for a copy of the information that we hold on you, for which we are entitled to charge a small fee and to have any inaccuracies in your information corrected. **Please write to: New Business Department, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.**

14 Access to medical reports

We may need to get 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 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. Your rights 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 starting your plan, your reinstatement or alteration. 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 6 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 3 years
- Your past health
  - Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your doctor 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 2 years, urinalyses (tests on urine), x-rays or other investigations
- Any blood pressure readings in the last 3 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 Human Immunodeficiency Virus (HIV), Hepatitis B or C
- Any sexually-transmitted diseases unless there could be long-term effects on your health; or
- Predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

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

- Refusing to provide insurance
- Increasing premiums above standard rates; or
- Setting premiums at standard rates.

If you have any questions about your rights or questions relating to the process of getting, assessing or storing medical information, please write to us at: New Business Department, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.

15 Declaration

Scottish Provident is a division of the Royal London Group which consists of The Royal London Mutual Insurance Society Ltd and its subsidiaries.

Please sign this declaration once you have read and agree to it, together with the important notes, data protection statement and notes on the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

I have read the answers to all the questions in this declaration of health form and I declare that the statements made in, or in connection with, this form, whether in my handwriting or not, are true and complete as far as I know. I understand that if I leave out any relevant information, or give incorrect information, it may lead to my plan not being started, reinstated or altered or being declared void.

If my circumstances change in any way before the plan starts, is reinstated or altered, I will tell you. I understand that if I do not do this, my plan may be declared void.

I agree to you or your agents asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess this declaration of health form. You may request relevant information from, or share relevant information with, other insurers in connection with this declaration of health form or any other of my applications for life, critical illness, sickness, disability, accident or private medical insurance. I authorise those asked to provide the requested medical information when they see a copy of this consent form.

I understand that you may request medical information within 6 months of the start, reinstatement or alteration of my plan in order to check the accuracy of any statement made in, or in connection with, this declaration of health form. If you choose to do this, I agree to you or your agents asking any doctor I have consulted about my physical or mental health and for those asked to provide the requested information. I understand that if any statement is inaccurate, and this affects your assessment of the insurance risk, my plan may be declared void.

I agree that my intermediary acts as my agent and, on my behalf, can:

- contact Scottish Provident about the plan,
- provide Scottish Provident with any information that is missing from my declaration of health form,
- accept terms offered to me by Scottish Provident, and
- instruct Scottish Provident to start, reinstate or alter my plan.

I have read the declaration, important notes, data protection statement and information relating to my rights under the Access to Medical Reports Act 1988 and Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

Please tick the box **if you want to see any** report before it is sent to us.

☐ First life ☐ Second life

I agree that this declaration of health form together with my application form, personal illustration / personalised key features and the product / technical guide including standard / policy provisions shall form the basis of the contract between me and Scottish Provident. **Please note** that for your own benefit and protection you should read these documents carefully before signing this declaration. If you do not understand any point please ask your intermediary for further information.

If you have not completed the declaration of health form yourself, **before you sign the declaration,** please read all of the answers and agree that they are accurate and complete. If you did not complete the form, who completed it on your behalf and what is their relationship to you (for example, intermediary, daughter, son etc)?

Print name and relationship

	First life	**Second life**
Signature of life assured		
Date	D D M M Y Y Y Y	D D M M Y Y Y Y
Name		