

AGENCY USE: Agency Number: Agency Name:

OFFICE USE: Contract: Client 1: Client 2:

Please complete this application in BLOCK CAPITALS and tick any relevant boxes. Once you have submitted this application you may ask for a copy to be sent to you.

SECTION 1 PERSONAL DETAILS

LIFE / LIVES TO BE ASSURED

First Life Details

Mr. Mrs. Ms.

First Name:

Surname:

Address:

Marital Status:

Date of birth:

Contact Number:

Email Address:

Country of residence:

Have you smoked any cigarettes, cigars, pipes or tobacco in the last 12 months? Yes No
If yes, how many per day?

Second Life Details

Mr. Mrs. Ms.

First Name:

Surname:

Address:

Marital Status:

Date of birth:

Contact Number:

Email Address:

Country of residence:

Have you smoked any cigarettes, cigars, pipes or tobacco in the last 12 months? Yes No
If yes, how many per day?

POLICY OWNER(S) (if different from above)

Policy Owner 1

Mr. Mrs. Ms.

First Name:

Surname:

Address:

Date of birth:

Contact Number:

Email Address:

Country of residence:

Policy Owner 2

Mr. Mrs. Ms.

First Name:

Surname:

Address:

Date of birth:

Contact Number:

Email Address:

Country of residence:

SECTION 2 PRODUCT DETAILS

Please select the basis of cover you want.

Single life: or Joint life: or Dual life:

Term Assurance: or Convertible Term Assurance:

Level of Benefit Level: or Increasing:

Please select the type of cover you want (one only).

Life cover only or Critical Illness cover only or Life & Critical Illness (Accelerated cover) or Life & Critical Illness (Double cover)

Term of cover (in years)

How much cover do you need?

	First Life (Both Lives if Joint Life Policy)	Second Life (if Dual Life Policy)
Life Cover:	€ <input type="text"/>	€ <input type="text"/>
Critical Illness Cover:	€ <input type="text"/>	€ <input type="text"/>

Frequency of premium: Monthly: Quarterly: Half Yearly: Annually:
Monthly premiums must be paid by direct debit

Policy start date:

Preferred Premium collection day
(Select a date your premium will be taken each month 1st - 28th)

wwwIf you wish to propose for Supplementary Benefits: Total and Permanent Disability, Guaranteed Increase Option, Hospital Cash or Waiver of Premium, please complete and attach a Supplementary Benefit Application form to this application.

SECTION 3 UNDERWRITING DETAILS

Instructions

- Please answer carefully, giving full details and, if necessary, use a separate sheet for additional information. If you need to alter an answer, please put a line through the incorrect part of the answer and initial the alteration.
- When completing this application form you must disclose all Material Facts. Failure to disclose all relevant facts, including full disclosure of your medical details and history, may delay or prevent the issue of your policy and/or invalidate future claims. If you are in any doubt as to whether a fact is a Material Fact you should disclose it.
- Please note: In answering the questions below, you do not need to disclose details relating to the following ailments: Acne, Anal fissure (single episode only), Hayfever (without asthma), Ganglion, Minor allergies, Thrush/ Candidiasis, Chickenpox, Colds/Influenza, Food poisoning, Measles, Heat stroke/Sunburn/Sunstroke, Laryngitis, Lockjaw (provided full recovery has been made), Mumps, Pharyngitis, Stomach bug (including gastroenteritis once fully recovered), Glandular fever (provided fully recovered), IGTN, Haemorrhoids/piles, Verucca, Childhood bronchitis, Pregnancy (assuming no complications), Miscarriage (assuming no complications), Sinusitis/Nasal Polyps, Tonsillitis/Quinsy
- You are not required to disclose any genetic test results you may have had and we will not have regard to any genetic tests which may come into our possession. You are, however, required to provide us with full details (other than genetic test) in answer to the health questions including full details about your family history as required in the health details section.

1. Are you due to have any check-up in the next 12 months in connection with any medical condition or symptoms, or are you waiting for the result of any medical investigation? If yes, please provide details.
2. Are you taking any medicine or drugs or receiving any treatment or are you experiencing any signs of ill health or disability for which you have not yet consulted a doctor? If yes, please provide details.
3. Have you in the last five years lived or worked abroad, are you currently doing so or do you intend to in the future? (Holidays, travel to, or residence in the EU, North America, Switzerland, Scandinavia, Australia or New Zealand can be ignored). If yes, please tell us where and for how long.
4. Have you ever tested positive for HIV/AIDS, Hepatitis B or C or have you been tested/ treated for any other sexually transmitted disease, or are you awaiting the results of any such tests? If yes, please provide details or, if you prefer, details may be sent to our Chief Medical Officer.
5. Have you ever been declined, postponed or accepted on special terms by Friends First or any other insurer for life, critical illness or income protection cover? If yes, please give details of the company and sum assured.
6. Have you applied, within the last 12 months or are you currently applying for Life or Critical Illness benefit with another insurer? If yes, please advise of insurer and amount.

First Life		Second Life	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Detail (Please indicate question and life assured).

Q.	

SECTION 3 UNDERWRITING DETAILS (CONTINUED)

7. Have either of your parents, or any brothers or sisters, died or suffered from heart disease, cardiomyopathy, a stroke, diabetes, high blood pressure, kidney disease, cancer, multiple sclerosis, nervous disorder, motor neurone disease, polycystic kidneys, polyposis of the colon or any hereditary disease such as Huntington's disease before age 65? If yes - please give full details i.e. which family member and age at diagnosis. If cancer, please advise site of same (e.g. colon, breast etc).

8. If yes: Please indicate if you currently have a GP.

Name of doctor:

Name of doctor:

Address:

Address:

9. In the event of Friends First needing to refer you to a doctor for an independent medical examination, please advise a convenient location and we will do our best to facilitate you.

10. Please tell us your height (without shoes) in feet/inches.

<input type="text"/>	<input type="text"/>
feet	inches

<input type="text"/>	<input type="text"/>
feet	inches

11. Please tell us your weight (in indoor clothes) in stone/lbs.

<input type="text"/>	<input type="text"/>
stone	lbs

<input type="text"/>	<input type="text"/>
stone	lbs

12. How many units of alcohol do you consume weekly?
(1 unit = 1/2 pint of beer or a glass of wine or standard spirit measure)

13. Have you ever been treated for alcohol abuse, or been advised by a doctor to cease or reduce your alcohol consumption, or taken drugs such as cannabis, cocaine, heroin or any non-prescribed drugs?

<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
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14. Do you, or do you intend to, engage in hazardous or extreme sports or pastimes of any kind e.g. mountaineering, motor sports, diving, equestrianism or aviation (other than as a fare paying passenger)? If yes, please provide details.

<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
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15. Are any of the following an important part of your occupation or working environment? If yes, please provide details, including your occupation title.

- a) Manual or physical activity or working at heights or depths
- b) Working in extreme temperatures
- c) Working with machinery or tools or with explosives or chemicals
- d) Working in the armed forces
- e) Working at sea/offshore

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Additional Detail (Please indicate question and life assured).

Q.	

For BrokerFirst online applications, please complete the following and forward only this declarations section to Friends First.

Online Application Number:

First Life Name:

Date of birth:

Second Life Name:

Date of birth:

SECTION 4 DECLARATIONS

a) Declarations

- I/We understand that this application, if partly completed online, shall consist of the declarations and consents made by me/us herein along with the details provided in my/our online application.
- I/We submit this application, along with any subsequent information provided in relation to this application, verbally or otherwise, by me/us or an agent acting on my/our behalf, with a view to entering into a contract for the benefits set out herein.
- I/We understand that the policy will commence on the commencement date indicated on the policy or on such other date as notified by Friends First.
- I/We understand that terms and conditions, as provided to me/us, will apply.
- I/We have read over the replies to all questions in this application and declare that to the best of my/our knowledge and belief, all information given is true and includes all material facts and I/we understand that failure to disclose all relevant facts, including full disclosure of my/our medical details and history, may delay or prevent the issue of my/our policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it.
- I/We consent to Friends First, verbally or otherwise, seeking and receiving additional information from me/us or my/our agents where this information has not been provided on the application or where further information is required in order to process the application and such information will be deemed to be incorporated into this application.
- I/We undertake to inform Friends First of any change in my/our country of residence during the life of the policy.
- I/We understand that Friends First must be notified of any changes in my/our health and/or circumstances prior to the assumption of risk.
- I/We understand that in the interest of customer service and to ensure the accuracy of records, telephone conversations between Friends First and me/us may be recorded.



Lives assured:
Please sign
and date.

Signatures of life/ lives to be assured:

Life 1

Date:

Life 2

Policy Owner(s): (if different from above)

Date:

b) Life Assurance (Provision of Information) Regulations, 2001

DECLARATION UNDER REGULATION 6(3) OF THE LIFE ASSURANCE (PROVISION OF INFORMATION) REGULATIONS, 2001.

WARNING If you propose to take out this policy in complete or partial replacement of an existing policy, please take special care to satisfy yourself that this policy meets your needs. In particular, please make sure that you are aware of the financial consequences of replacing your existing policy. If you are in doubt about this, please contact your insurer or insurance intermediary.

Ref. Policy Number

Declaration of Insurer or Intermediary

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001, _____ (the client) has been provided with the information specified in Schedule 1 to those Regulations and that I have advised the client as to the financial consequences of replacing an existing policy with this policy by cancellation or reduction, and of possible financial loss as a result of such replacement.

Signature of Financial Adviser:

Date:

Declaration of Client

I confirm that I have received in writing the information specified in the above declaration.

Policy Owner(s):

Date:



Financial Adviser:
Please sign
and date.



Policy Owner(s):
Please sign
and date.

Friends First Life Assurance Company Ltd
Friends First House
Cherrywood Business Park
Loughlinstown
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