

DATA CAPTURE FORM PROTECTION



NEW IRELAND
ASSURANCE

Please tick [✓] where appropriate

Person(s) to be covered

	First person to be covered	Second person to be covered																																
Title:	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other																																
Surname:	<input type="text"/>	<input type="text"/>																																
First Name:	<input type="text"/>	<input type="text"/>																																
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female																																
Date of Birth:	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed																																
Address:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>																																
Occupation:	<input type="text"/>	<input type="text"/>																																
Telephone:	Home <input type="text"/> Work <input type="text"/> Mobile <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>																																
E-mail:	<input type="text"/>	<input type="text"/>																																

Policy Owner(s) (Complete only if different from above)

	First policy owner	Second policy owner																																
Title:	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other																																
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Address:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>																																
Occupation:	<input type="text"/>	<input type="text"/>																																

Reason for cover

Is the relationship between the policy owner(s) and person(s) to be covered husband and wife or joint mortgagees? If 'No' please give the reason for the policy:

Yes No

Please tick (✓) the protection policy you are applying for (one box only):

Mortgage Protection **Term Assurance** **TotalCare**

Preferred policy start date:

D	D	M	M	Y	Y	Y	Y

Note: If you wish to apply for two or more policies a separate Data Capture Form and Declaration Capture Form form **must** be used for each product.

Mortgage Protection

Term of Cover

 years

Please tick (✓) one of the following options only:

1. **Life Cover Benefit Only**

or

2. **Life Cover Benefit with Accelerated Critical Illness Benefit**

(Life Cover Benefit is reduced by the amount of a Critical Illness or TPD claim.)

Life Cover Benefit Only

or

Accelerated

Amount to be covered

Life Cover Benefit

 €

Accelerated Critical Illness Benefit

(The Critical Illness Benefit may not exceed the Life Cover Benefit.)

 €

Optional Benefits:

A. Total & Permanent Disability Benefit (TPD)

(Not available for Life Cover Benefit Only option.)

Own Occupation – You must be unable to perform your own occupation.

Any Occupation – You must be unable to perform any occupation at all.

B. Hospital Cash Benefit (€70 per day)

First person

Own Any

Yes

Second person

Own Any

Yes

Term Assurance

Term of Cover

 years

Increasing Benefits & Premiums

Yes

Conversion Option

(Only applies to the Life Cover Benefit.)

Yes

Please tick (✓) one of the following options only:

1. **Life Cover Benefit Only**

or

2. **Life Cover Benefit with Accelerated Critical Illness Benefit**

(Life Cover Benefit is reduced by the amount of a Critical Illness or TPD claim.)

Life Cover Benefit Only

or

Accelerated

Amount to be Covered

Life Cover Benefit

 €

 €

Accelerated Critical Illness Benefit

(The Critical Illness Benefit may not exceed the Life Cover Benefit)

 €

 €

Optional Benefits:

A. Total & Permanent Disability Benefit (TPD)

(Not available for Life Cover Benefit Only option.)

Own Occupation – You must be unable to perform your own occupation.

Any Occupation – You must be unable to perform any occupation at all.

B. Hospital Cash Benefit (€70 per day)

First person

Own Any

Yes

Second person

Own Any

Yes

Please tick (✓) one of the following options only:

1. Life Cover Benefit Only

or

2. Life Cover Benefit with Accelerated Critical Illness Benefit

(Life Cover Benefit is reduced by the amount of a Critical Illness or TPD claim. The Critical Illness Benefit may not exceed the Life Cover Benefit)

or

3. Life Cover Benefit with Additional Critical Illness Benefit

(Payment of a Critical Illness or TPD claim does not affect Life Cover Benefit.)

or

4. Critical Illness Benefit Only

First person

Second person

Life Cover Benefit Only

or

Accelerated

or

Additional

or

Critical Illness Benefit Only

Life Cover Benefit Only

or

Accelerated

or

Additional

or

Critical Illness Benefit Only

Amount to be Covered

Life Cover Benefit

€

€

Critical Illness Benefit

€

€

Optional Benefits:

Options A and B are not available with Life Cover Benefit Only (option 1 above).

A. Total & Permanent Disability Benefit (TPD)

Own Occupation – You must be unable to perform your own occupation.

Any Occupation – You must be unable to perform any occupation at all.

Own Any

Own Any

B. Surgical Cash Benefit

Yes

Yes

C. Accident Benefit

(Benefit in the event of a claim is limited to 50% of average earnings over the last year.)

€125 € Other

€125 € Other

D. Specified Injury Benefit

Yes

Yes

E. Hospital Cash Benefit per day

€70 € Other

€70 € Other

F. Waiver of Premium Benefit

Yes

Not Applicable

Investment will be in New Ireland's Balanced Managed Fund.

Payment details Please complete irrespective of policy selected.

Premium: €

Frequency: Monthly Quarterly Half Yearly Annually

Payment Method: Direct Debit (see Section 12) Cheque/Draft (Half Yearly or Annually frequencies only).

For further details on any protection policy please consult your adviser or the product brochure.

Occupational Details

	First person		Second person		First person	Second person
1. Does your occupation involve:	Yes	No	Yes	No		
a) Manual work? If "Yes" give details including % of working week on manual work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
b) Use of machinery or tools? If "Yes" give details including % of working week using machinery or tools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
c) Working at heights? If "Yes" what is the average and maximum height you work at including % of working week working at heights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
d) Driving? If "Yes" please give vehicle type and number of miles driven per week.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
e) Work at sea, work underground or the use of explosives? If "Yes" give details including % of working week spent in any of these situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. a) Have you smoked cigarettes, cigars, or pipe tobacco in the last 12 months?					Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) If "Yes", how much do you smoke each day or if you have stopped smoking in the last 12 months how much did you smoke each day?					<input type="text"/> per day	<input type="text"/> per day
3. What is your average weekly consumption of alcohol in units?					<input type="text"/> units per week	<input type="text"/> units per week
Unit guide: Bottle beer = 1.5 units, Pint beer = 2.0 units Bottle wine = 7.0 units Measure spirits = 1.0 units, Glass wine = 1.0 units.					<input type="text"/> ft <input type="text"/> ins <input type="text"/> st <input type="text"/> lbs	<input type="text"/> ft <input type="text"/> ins <input type="text"/> st <input type="text"/> lbs
4. What is your height and weight?						
5. Have any of your natural parents, brothers, or sisters suffered or died before age 66 from the following? Heart disease (including Cardiomyopathy), stroke, high blood pressure, Haemochromatosis, Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease, Huntington's Disease, Muscular Dystrophy, Diabetes, kidney disease (including Polycystic Kidney disease), Cancer, Polyposis of the colon, paralysis or any other hereditary/familial disorder. If "Yes", please complete the section below.					Yes <input type="checkbox"/>	No <input type="checkbox"/>

First person

Relative	Age at Diagnosis	Condition <small>(If cancer, specify the part of the body affected first, eg. bowel) (If heart disease, specify exact nature of heart disease)</small>	Have you ever had, or been advised to have any check-up/screening because of your family history? If Yes, please give details.

Second person

Relative	Age at Diagnosis	Condition <small>(If cancer, specify the part of the body affected first, eg. bowel) (If heart disease, specify exact nature of heart disease)</small>	Have you ever had, or been advised to have any check-up/screening because of your family history? If Yes, please give details.

■ If "Yes" to any of the following questions please complete the appropriate Questionnaire in order to assist you in completing the Online Application. If there is not a Questionnaire for a disclosed condition, please complete an 'Other Medical Disclosure' Questionnaire.

	First person		Second person		First person	Second person
Please tick (✓) where appropriate	Yes	No	Yes	No		
6. Have you attended your doctor in the last five years? (You may ignore colds, flus, contraception and uncomplicated pregnancy).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Have you attended any other doctor, specialist or consultant, hospital or clinic, for any medical advice, check up, test, treatment or investigation in the last five years? (You may ignore colds, flus, contraception and uncomplicated pregnancy).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Are you currently having any sort of treatment or medical care of any kind, including prescribed medicine or drugs? If "Yes", please enter the name of the condition(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

	First person		Second person		First person	Second person
Please tick (✓) where appropriate						
9. Have you ever tested positive for HIV/AIDS or Hepatitis B or C, or had a blood or any other test in connection with any sexually transmitted disease, or are you awaiting the result of any such tests?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
10. Have you ever had in-patient treatment for alcohol abuse, been given advice by a doctor to cease or reduce your alcohol consumption or taken drugs for other than medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11. Have you ever suffered from or had treatment for:						
a) A stroke, high blood pressure, chest pain, high cholesterol, heart attack, angina, or any disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
b) Diabetes or any disease or disorder of the stomach, liver, pancreas or bowel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
c) Any form of cancer, or had any tests for cancer, tumour, lump, mole or growth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
d) Any kidney or bladder disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
e) Asthma, bronchitis or any lung disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
f) Anxiety, stress, depression or any other mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
g) Any tremor, dizziness, numbness, pins and needles, blurred or double vision, Multiple Sclerosis, fits, seizure or Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
h) Any form of paralysis or any disease, disorder or injury to the brain, spinal cord or nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
i) Arthritis, slipped disk, sciatica or any joint or back disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
j) Any disease or disorder of the ears or eyes (other than problems corrected by prescribed glasses or contact lenses)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
k) Any physical or mental illness or injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					First person	Second person
12. a) Name and address of your Doctor: If none please write "None"					<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Have you changed your doctor, or attended any other doctor, in the last 12 months? If "Yes" give the name(s) and address(es).					<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please tick (✓) where appropriate

Hobbies and Residential

13. Do you have any intention of:

- a) Flying other than as a passenger on a public airline? (If Yes, please complete the appropriate questionnaire)
- b) Scuba diving, mountaineering, rock climbing or participating in any other hazardous hobby, sport or motorsport? (If Yes, please complete the appropriate questionnaire)
- c) Living or travelling outside the EU, North America or Australia other than for holidays?

If "Yes", please complete appropriate Questionnaire in order to assist you in completing the Online Application.

14. Have you lived outside of Ireland, the United Kingdom, North America or Australia for greater than 6 months in the last 10 years?
If "Yes" where, when and for how long?

Additional Policies

15. Have you in the last 12 months submitted, or are you about to submit any application for death or critical illness benefit on your life to any Insurance Office? If "Yes" provide the reason for cover and the sum assured.

16. Have you ever had an application on your life declined, postponed, accepted at an increased premium or with an exclusion imposed for any death, critical illness or disability benefit? If "Yes" provide the reason for cover and the sum assured.

- 17. a) Is your life already insured with New Ireland? If "Yes" please state policy numbers.
- b) Is this application to replace an existing New Ireland policy? If "Yes" please state the policy number to be replaced.

18. Do you have any existing Critical Illness insurance in force? If "Yes" please state amount and reason.

19. Does the total amount of life and stand alone critical illness cover you are currently insured for, currently applying for or considering applying for exceed an amount of €15,000,000? (Types of cover include but are not limited to any personal cover, mortgage cover (commercial or personal), business and death in service cover). If your total cover exceeds €15,000,000 provision of any cover under this application will be subject to the company obtaining cover in the reinsurance market.

	First person		Second person		First person	Second person
	Yes	No	Yes	No		
a)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
c)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
14.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
15.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
16.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17. a)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17. b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

New Ireland Assurance Company plc.,

11-12 Dawson Street, Dublin 2.

T: (01) 617 2000 F: (01) 617 2800.

E: info@newireland.ie W: www.newireland.ie

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New Ireland Assurance Company plc is regulated by the Financial Regulator.

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