Application Form

International Protector Middle East

FRIENDS PROVIDENT INTERNATIONAL
فريندز بروفيدنت انترناشيونال

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 1 – Introduction – It is most important that you read this part before completing the application form.

If you make any mistakes while completing this application form, please cross out the error and write the new information clearly. The person(s) completing the form must initial each correction. Do not use correction fluid or other ways of deleting incorrect information.

If you require more space to write your answers, please attach an additional sheet to this application, and write on this form that you have done so.

1 Disclosure of all relevant information

- **Help us to assess your application by giving us all the information we ask for. All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we may have the legal right to cancel any policy issued as a result of your application and to not pay any claim.**
- **IF ANYTHING ABOUT YOUR HEALTH OR CIRCUMSTANCES CHANGES AFTER YOU HAVE COMPLETED THIS APPLICATION, AND BEFORE WE START THE COVER APPLIED FOR, YOU MUST LET US KNOW IMMEDIATELY.**
  We need to know of any changes which would have resulted in different replies to questions asked either: on or resulting from the application form or other questionnaire; or by any doctor or nurse acting on our behalf.
  To inform us of any such change, please telephone our Dubai office on +9714 436 2800.

  Changes would include having, or expecting to have, doctor, hospital or clinic consultations, treatment as an in-patient or out-patient or a blood test for any reason. We also need to know immediately if you change your occupation, country of residence or take up any hazardous sports or pastimes before cover starts.
- If we are advised of any changes we will confirm in writing whether or not any terms quoted will still apply.

2 Terms and conditions

- You should seek guidance from your usual Financial Adviser as to the suitability of the policy to your own particular circumstances.
- Once your Application has been processed and accepted, you will receive a copy of our policy conditions; along with your personal policy schedule(s). Please ensure you read these documents in full during the 'cooling off' period.

  An electronic copy of the policy conditions can be requested from your financial adviser at any time prior to receiving the copy that is sent with your policy schedule(s).
- **Important: Please be aware that the policy conditions sent with your policy schedule(s) will be the ones that apply to your policies; therefore, these documents should be kept safe.**
- You are entitled to ask for a copy of your Application form at any time.

3 Medical evidence

WE WILL ONLY PAY FOR MEDICAL INFORMATION WHICH WE HAVE SPECIFICALLY REQUESTED.

Details of Financial Adviser To be completed by the Financial Adviser

Financial Adviser company name and address (or stamp)

Agent reference or adviser's name

Email address

Agency number | 7 | 9 | 1 | | | | | | e.g. 791 00000

Telephone

Fax

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 2 – Personal details of life/lives assured

The life/lives assured is/are the person(s) on whose life (lives) the policy will be written. Please complete in block capitals.

	First (or only) Life	Second Life
1 Title eg Mr, Mrs, Dr, Miss		
	Male ☐ Female ☐	Male ☐ Female ☐
2 Last name		
3 First name(s)		
4 Current residential address (including street name, town and area code if known)		
5 Correspondence address (if different)		
6 Telephone number(s) (At least one telephone number is mandatory for each life assured)	Work	Work
	Home	Home
	Mobile	Mobile
7 Email address		
8 ID or passport number		
9 Permanent residency visa number (if applicable)		
10 Date of birth (ddmmyy)		
11 Marital status		
12 Relationship or nature of interest between the two lives to be assured (if applicable)		
13 a Do you have a regular doctor or medical practitioner? If yes, provide **full** name and address of your regular doctor or medical practice/centre including fax number.	Yes ☐ No ☐	Yes ☐ No ☐
Please note we might not contact your doctor. Even if we do, you must still disclose all facts when completing this application.	Telephone	Telephone
	Fax	Fax
b How long has your regular doctor known you?	years	years
14 a When did you last attend **any** doctor or medical professional?		
b What was the reason for your last visit?	Reason	Reason

Part 3 – Occupation

	First (or only) Life	Second Life
1a What is your occupation? (If you have more than one occupation, please provide full details of each one)		
1b What is the **name** and **address** of your employer and the **nature of your employer's business** (e.g. Oil & natural gas, Construction, Financial Services etc)?		
1c Please give details if you work underground, underwater, at heights over 3 metres, offshore or any other hazardous aspects of your occupation	Full details to include percent of working time spent at heights and average and maximum heights worked at (if applicable.)	Full details to include percent of working time spent at heights and average and maximum heights worked at (if applicable.)

Part 4 – Plan details

Required currency: USD ($) ☐ GBP (£) ☐ EUR (€) ☐ AED ☐

Premium payable: Monthly ☐ Annually ☐

Please see the information in Part 14 before choosing your premium frequency and premium payment method.

Premium payment method: Standing order ☐ Credit card ☐ Cheque/post-dated cheque ☐ Bank transfer ☐

A – Life Cover – Level Sum Assured

First Life Only
Sum assured | Term (years)
Total and Permanent Disability Benefit (Tick if required) ☐

Second Life Only
Sum assured | Term (years)
Total and Permanent Disability Benefit (Tick if required) ☐

Joint Life
Sum assured | Term (years)
Total and Permanent Disability Benefit
First life ☐ (Tick if required)
Second life ☐ (Tick if required)

B – Life or Earlier Critical Illness Cover – Level Sum Assured

First Life Only
Sum assured | Term (years)

Second Life Only
Sum assured | Term (years)

Joint Life
Sum assured | Term (years)

C – (Stand-alone) Critical Illness Cover – Level Sum Assured

First Life Only
Sum assured | Term (years)

Second Life Only
Sum assured | Term (years)

Joint Life
Sum assured | Term (years)

D – Life Cover – Decreasing Sum Assured

First Life Only
Sum assured | Term (years)
Interest rate 7% ☐ or 11% ☐
Total and Permanent Disability Benefit (Tick if required) ☐

Second Life Only
Sum assured | Term (years)
Interest rate 7% ☐ or 11% ☐
Total and Permanent Disability Benefit (Tick if required) ☐

Joint Life
Sum assured | Term (years)
Interest rate 7% ☐ or 11% ☐
Total and Permanent Disability Benefit
First life ☐ (Tick if required)
Second life ☐ (Tick if required)

E – Life or Earlier Critical Illness Cover – Decreasing Sum Assured

First Life Only
Sum assured | Term (years)
Interest rate 7% ☐ or 11% ☐

Second Life Only
Sum assured | Term (years)
Interest rate 7% ☐ or 11% ☐

Joint Life
Sum assured | Term (years)
Interest rate 7% ☐ or 11% ☐

Start date

Should anything about your health or other circumstances change before we have started the policy you have applied for, you must tell us immediately. We will then confirm in writing whether any terms we have quoted will remain available. Failure to notify us of any such change may result in the policy becoming void and the benefits not becoming payable

We will start your policy immediately if your application is accepted on our normal terms, unless you state a date below on which you would like it to start or have instructed us otherwise.

If your application is not accepted on our normal terms, the policy will not start until we receive written notification of your acceptance of any revised terms we offer, and your instruction for the policy to start.

We also need to have received your first premium or a completed banker's standing order or credit card instruction.

Effective date (ddmmyy) | | | | | | |

Part 5 – Residential and travel details

	First (or only) Life	Second Life
1 What are your nationalities? Please list all. If you intend to change your country of residence, please provide full details.		
2 Country of birth		
3 Town of birth		
4 What is your current country of residence?		
5 What is the legal basis of your stay in the current country of residence (eg permanent resident visa)?		
6a How long have you lived in your current country of residence?		
6b How long do you intend to stay in your current country of residence? If you intend to change your country of residence, please provide full details.		
7 In which countries have you lived and for how long?		
8a Has your occupation involved travel outside your current country of residence in the last two years? If yes, please give details including **specific countries** visited, dates and duration of stay.	Yes ☐ No ☐ Details (Include countries, dates and durations)	Yes ☐ No ☐ Details (Include countries, dates and durations)
8b Do you expect your occupation to involve travel outside your current country of residence in the future? If Yes, please give details including **specific countries** to be visited, dates and duration of stay.	Yes ☐ No ☐ Details (including countries, dates and durations)	Yes ☐ No ☐ Details (including countries, dates and durations)

Part 6 – Recreation details

To qualify as a 'non-smoker' you must not have used any form of tobacco or nicotine products within the last 12 months.

	First (or only) Life	Second Life
1 Have you smoked or used any form of tobacco (for example cigarettes, cigars, pipe tobacco, shisha pipe) or nicotine product (for example nicotine patches, nicotine gum) in the last 12 months?	Yes ☐ No ☐ (Random tests may be carried out to verify non-smoker status)	Yes ☐ No ☐
If yes, what form and how much a day?	eg cigarettes, 20 per day	eg cigarettes, 20 per day
If you have given up, when did you last use tobacco, what form and how much a day did you previously use?		
2a Do you drink alcohol?	Yes ☐ No ☐	Yes ☐ No ☐
If yes, how many units a week?	Units per week (1 unit = a single measure of spirits or 1 glass of wine (125ml) or ½ pint (250ml) of beer).	Units per week
b Have you ever been advised by a doctor or any other medical practitioner to reduce or stop your alcohol consumption on medical grounds or have you ever taken part in counselling, therapy or a programme with the aim of reducing or stopping your alcohol consumption?	Yes ☐ No ☐ Details	Yes ☐ No ☐ Details
3 In the last 7 years have you taken any non-prescription drugs (for example LSD, ecstasy, cocaine, heroin, cannabis, anabolic steroids etc)?	Yes ☐ No ☐ Details	Yes ☐ No ☐ Details
4 Do you take part in any hazardous sport or pastime or do you intend to start? (Mountaineering, motor sport, sub-aqua diving and private flying are examples but you should include any activity that is hazardous. You do not need to include sports such as horse riding, skiing, football, rugby, hockey, cricket or racquet sports)	Yes ☐ No ☐ Details	Yes ☐ No ☐ Details

Part 7 – Financial details

Where requested please give us as much information as possible in order to avoid needing to go back to you for further clarification.

For higher sums assured we may require further evidence. Where possible we have asked for this to be attached to the proposal form so we can underwrite this as soon as possible. To determine financial underwriting requirements the following currency conversions will be used:

US dollars	British pounds	euros	UAE dirhams
500,000	285,000	421,800	1,840,000
1,000,000	565,000	836,000	3,680,000
2,000,000	1,125,000	1,665,000	7,360,000
5,000,000	2,850,000	4,218,000	18,400,000

You are reminded that your answers in this section form part of your application and failure to give accurate and complete answers may result in non-payment of a claim.

	First (or only) Life	Second Life
1 Annual earned income	Currency (eg USD)	Currency (eg USD)
	Amount	Amount

Part 7 – Financial details (continued)

2a **First (or only) life**

Do you have any existing life, disability, or critical illness insurance on your life? Yes ☐ No ☐

(If yes, please give details below)

Type of cover (e.g. Life, critical illness, etc	Country of insurance	Name of insurer	Sum assured (including currency)	Start date and term	Reason for policy

Second life

Do you have any existing life, disability, or critical illness insurance on your life? Yes ☐ No ☐

(If yes, please give details below)

Type of cover (e.g. Life, critical illness, etc	Country of insurance	Name of insurer	Sum assured (including currency)	Start date and term	Reason for policy

	First (or only) Life	Second Life
b Are any of these policies to be cancelled once this application is in force?	Yes ☐ No ☐ Company and policy reference	Yes ☐ No ☐ Company and policy reference
c If total amount of cover in existence, plus this application, is greater than either US$2M of life assurance or US$500,000 of critical illness insurance, or equivalent, please attach evidence of earned income for the main earner.	Please tick if attached ☐ (eg latest tax statement, statement from employer, last 3 months' payslips)	
3 Apart from the above, have you applied to any other company for life, disability or critical illness insurance in the last 12 months or are you about to?	Yes ☐ No ☐ Company Date Details including sums assured and reason for policies Is only one application to proceed?	Yes ☐ No ☐ Company Date Details including sums assured and reason for policies Is only one application to proceed?
4 Have you ever applied for life assurance, insurance against 'critical illness' or income protection / disability insurance and been turned down or asked to pay a higher premium or have other special terms been imposed?	Yes ☐ No ☐ Company Full details including reason for adverse decision, company and sum assured Date	Yes ☐ No ☐ Company Full details including reason for adverse decision, company and sum assured Date

Part 7 – Financial details (continued)

5 Please complete one section from **either** personal cover (a) **or** business protection (b)

a) Personal Cover

Complete each appropriate section

☐ Personal protection (ie family cover)

	First (or only) Life	Second Life
Please tell us the relationship and ages of any dependents		

Please contact your local Friends Provident International Limited branch to discuss requirements for sums assured greater than US$4M.

☐ Personal loan protection (including mortgage)

What is the reason for the loan? If it is for a mortgage, please tell us whether it is for your own main residence or investment.

Name of lender

Amount and duration of loan

Is the loan conditional on issue of this policy? Yes ☐ No ☐

If the sum assured is above US$1M for life assurance or US$500,000 for critical illness insurance, or equivalent, please attach a copy of the loan offer letter or evidence of the debt. Please tick if attached ☐

b) Business Protection

This includes keyman protection, partnership or shareholder protection or a loan taken out on behalf of a business.

What is the reason for the cover and how was this sum assured derived?

If the sum assured is above US$1M for life assurance or US$500,000 for critical illness insurance, or equivalent, please complete our Business Financial Underwriting Questionnaire and attach to this application. Please tick if attached ☐

Part 8 – Family history

First (or only) Life

Before the age of 60, have any of your natural parents, brothers or sisters had, or died from, heart disease, stroke, diabetes, cancer, Huntington's disease, polycystic kidney disease, polyposis of the colon, multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neurone disease, muscular dystrophy or any hereditary disorder not already listed above? Yes ☐ No ☐

If Yes, please complete the relevant section(s) below with details of any of the conditions listed above. Please state the **age at onset of the medical condition** and in the case of cancer, which part of the body was **first affected**.

Relationship to you of person affected	Medical condition	Age at onset of condition

Second Life

Before the age of 60, have any of your natural parents, brothers or sisters had, or died from, heart disease, stroke, diabetes, cancer, Huntington's disease, polycystic kidney disease, polyposis of the colon, multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neurone disease, muscular dystrophy or any hereditary disorder not already listed above? Yes ☐ No ☐

If Yes, please complete the relevant section(s) below with details of any of the conditions listed above. Please state the **age at onset of the medical condition** and in the case of cancer, which part of the body was **first affected**.

Relationship to you of person affected	Medical condition	Age at onset of condition

Part 9 – Health questions – First (or only) Life

All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we may have the legal right to cancel any policy issued as a result of your application and to not pay any claim.

If the answer to any question is 'Yes' please give full details disclosing all facts as they can influence the assessment and acceptance of the application.

1 a What is your height? _____ cm

b What is your weight? _____ kg

c Apart from intentional weight loss (eg diet) or pregnancy, have you lost more than 6 kilograms in the last six months? Yes ☐ No ☐

2 Do you currently have or have you ever had any of the following:

a Cancer, leukaemia, Hodgkin's disease, lymphoma or a brain or spinal tumour? Yes ☐ No ☐

b Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat? Yes ☐ No ☐

c A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage? Yes ☐ No ☐

d Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia? Yes ☐ No ☐

e Visual disturbance, blurred or double vision, optic or retrobulbar neuritis? Yes ☐ No ☐

f Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which you consulted a doctor or hospital? Yes ☐ No ☐

g Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Yes ☐ No ☐

(If the result was negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance)

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

3 In the last 5 years have you had any of the following:

a Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance? Yes ☐ No ☐

b Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised? Yes ☐ No ☐

c Asthma, bronchitis, tuberculosis, coughing with blood or any chest, lung or breathing disorder? Yes ☐ No ☐

d Recurrent headache for which you have consulted a doctor or any epilepsy, seizure, fit or blackout? Yes ☐ No ☐

e Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore sight problems corrected by glasses or contact lenses but you must tell us about all hearing problems, even if corrected by hearing aid(s)) Yes ☐ No ☐

f Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which you have consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which you have taken time off work? Yes ☐ No ☐

g Diabetes, Crohn's disease or colitis? Yes ☐ No ☐

h Any disorder of the kidneys? Yes ☐ No ☐

i Treatment or a positive test for any disease which was transmitted sexually? Yes ☐ No ☐

j (i) Any mental illness or eating disorder or have you attempted self-harm or taken an overdose? Yes ☐ No ☐

(ii) Any other feeling of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner? Yes ☐ No ☐

k Within the last 5 years have you been exposed to the risk of HIV infection? Yes ☐ No ☐

(HIV can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union)

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

Part 9 – Health questions – First (or only) Life (continued)

4 In the last 2 years, other than for those conditions you have already mentioned:

a Have you had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient? Yes ☐ No ☐

b Have you had, or been advised to have, any medical investigation, x-ray, scan or test? (For this question, you do not need to give details of occasional consultations with your regular doctor for colds, flu, or consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

5 In the last 12 months have you been prescribed any drug, medicine or tablet, or have you had any other form of medical treatment (for example physiotherapy, psychotherapy)? Yes ☐ No ☐

6 In the last 6 months have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have not consulted a doctor, hospital or medical practitioner? (For this question, you do not need to give details of colds and flu which have lasted less than 2 weeks in total) Yes ☐ No ☐

7 In the next 12 months are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation? Yes ☐ No ☐

8 Other than the information you have already provided, have you ever had an illness or medical condition that has lasted more than 3 months and which affected your ability to study or perform normal daily activities or for which you took more than 2 weeks off work? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

Additional information

Part 9 – Health questions – Second Life

All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we may have the legal right to cancel any policy issued as a result of your application and to not pay any claim.

If the answer to any question is 'Yes' please give full details disclosing all facts as they can influence the assessment and acceptance of the Application.

1 a What is your height? _____ cm

b What is your weight? _____ kg

c Apart from intentional weight loss (eg diet) or pregnancy, have you lost more than 6 kilograms in the last six months? Yes ☐ No ☐

2 Do you currently have or have you ever had any of the following:

a Cancer, leukaemia, Hodgkin's disease, lymphoma or a brain or spinal tumour? Yes ☐ No ☐

b Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat? Yes ☐ No ☐

c A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage? Yes ☐ No ☐

d Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia? Yes ☐ No ☐

e Visual disturbance, blurred or double vision, optic or retrobulbar neuritis? Yes ☐ No ☐

f Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which you consulted a doctor or hospital? Yes ☐ No ☐

g Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Yes ☐ No ☐

(If the result was negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance)

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

3 In the last 5 years have you had any of the following:

a Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance? Yes ☐ No ☐

b Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised? Yes ☐ No ☐

c Asthma, bronchitis, tuberculosis, coughing with blood or any chest, lung or breathing disorder? Yes ☐ No ☐

d Recurrent headache for which you have consulted a doctor or any epilepsy, seizure, fit or blackout? Yes ☐ No ☐

e Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore sight problems corrected by glasses or contact lenses but you must tell us about all hearing problems, even if corrected by hearing aid(s)) Yes ☐ No ☐

f Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which you have consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which you have taken time off work? Yes ☐ No ☐

g Diabetes, Crohn's disease or colitis? Yes ☐ No ☐

h Any disorder of the kidneys? Yes ☐ No ☐

i Treatment or a positive test for any disease which was transmitted sexually? Yes ☐ No ☐

j (i) Any mental illness or eating disorder or have you attempted self-harm or taken an overdose? Yes ☐ No ☐

(ii) Any other feeling of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner? Yes ☐ No ☐

k Within the last 5 years have you been exposed to the risk of HIV infection? (HIV can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

Part 9 – Health questions – Second Life (continued)

4 In the last 2 years, other than for those conditions you have already mentioned:

a Have you had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient? Yes ☐ No ☐

b Have you had, or been advised to have, any medical investigation, x-ray, scan or test? (For this question, you do not need to give details of occasional consultations with your regular doctor for colds, flu, or consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

5 In the last 12 months have you been prescribed any drug, medicine or tablet, or have you had any other form of medical treatment (for example physiotherapy, psychotherapy)? Yes ☐ No ☐

6 In the last 6 months have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have not consulted a doctor, hospital or medical practitioner? (For this question, you do not need to give details of colds and flu which have lasted less than 2 weeks in total) Yes ☐ No ☐

7 In the next 12 months are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation? Yes ☐ No ☐

8 Other than the information you have already provided, have you ever had an illness or medical condition that has lasted more than 3 months and which affected your ability to study or perform normal daily activities or for which you took more than 2 weeks off work? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

Additional information

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 10 – Applicant(s) details – The Applicant(s) is/are the person(s) who are to be the owner(s) of the policy.

Is/are the applicant(s):

- ☐ **the first or only life assured?**
- ☐ **the second life assured?**
- ☐ **both lives assured?**
- ☐ **neither life/lives assured? If neither, please complete Part 10 in full.**

	First (or only) applicant	Second applicant
1 Title eg Mr, Mrs, Dr, Miss		
	Male ☐ Female ☐	Male ☐ Female ☐
2 Last name		
3 First name(s)		
4 Company/trust name		
5 Current residential/registered address (including street name, town and area code if known)		
6 Telephone number(s)	Work	Work
	Home	Home
7 Email address		
8 ID or passport number		
9 Date of birth (ddmmyy)		
10 Marital status		
11 Nationality		
12 Town of birth		
13 Country of birth		
14 Country of permanent residence (if different to above)		
15 Relationship or nature of interest in the person(s) named in Part 2		

Part 11 – Access to existing medical reports

Please note we might not contact your doctor. Even if we do, you must still disclose all the facts when completing this application form.

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.

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.

We ask your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C; or
- Any sexually-transmitted diseases unless there could be long-term effects on your health.

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

- Refusing to provide insurance;
- Increasing premiums above standard rates;
- Applying an exclusion to the cover; or
- Setting premiums at standard rates.

If you have any questions relating to the process of getting, assessing or storing medical information, please write to:

The Chief Medical Officer, c/o Friends Provident International Limited, Emaar Square, Building 6, Floor 5, PO Box 215113, Dubai, United Arab Emirates.

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 12 – Declaration **This Declaration must be signed by all persons involved in this application.**

1 • This application is my official request to enter into a contract with Friends Provident International Limited providing the foregoing policy. I understand and accept that the contract will be on Friends Provident International Limited's normal terms and conditions.
• I understand and accept that Friends Provident International Limited is subject to the supervisory arrangements and laws of the United Arab Emirates and the Isle of Man.
• I understand and accept that International Protector Middle East is governed by the laws of the United Arab Emirates and all disputes relating to a policy shall be subject to the jurisdiction of the courts of the United Arab Emirates, except as otherwise expressly agreed by the parties in writing.
• I understand and accept that this application can only be accepted by employees of Friends Provident International Limited and that no other parties have the necessary authority to create a binding contract.

2 • I/We acknowledge that in the event of any premium tax or withholding tax being levied in my/our country of residence it will be my/our responsibility to increase the regular premium by an amount equal to the liability or to settle the liability directly with the relevant tax authorities.

3 • Where I am a life assured but not an applicant, I consent for this application to proceed on my life.

4 • I understand and accept Friends Provident International Limited may require sight of my medical records to consider a claim.
• I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual organisation or government office that has any records or knowledge of me or my health to disclose to Friends Provident International Limited any information for the purpose of considering a claim. This authorisation shall irrevocably bind my successors and assigns and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

5 • I understand that information given to Friends Provident International Limited in connection with this application may be used by Friends Provident International Limited in its consideration of any claim in future and may be shared with a third party eg medical examiner, to help in the assessment of a claim.
• I understand that you will pass the information about any claim concerning critical or disability illness insurance to the Association of British Insurers (ABI) so that they can make it available to other insurers. I also understand that, in response to any searches you make in connection with this claim, the ABI may pass you information it has received from other insurers.

6 • I understand and accept that the terms and conditions and a copy of this completed application are available on request.
• I understand and accept that where I am applying on the advice of a Financial Adviser, that Financial Adviser is acting on my behalf and not as an agent of Friends Provident International Limited.

7 • **I have read Part 1 – Introduction and my answers to the questions in this application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no fact has been withheld. I understand I must ensure that all facts I disclosed to my Financial Adviser in answer to the questions in this application are accurately recorded in this application. I understand and accept that failure to disclose a fact or the giving of false information may give Friends Provident International Limited the right to cancel from inception any policy issued as a result of this application and may invalidate any future claim.**
• **I understand that I must tell Friends Provident International Limited without delay if my health or circumstances change before Friends Provident International Limited assumes risk for the policy applied for.**

8 • I accept that if I am required to have a medical examination, the replies to the medical examiner's questions will form part of this application.
• I understand and agree Friends Provident International Limited will use the information I give (as well as information about me relating to any existing policy I may have with Friends Provident International Limited) for administration, underwriting, claims, research and statistical purposes. I authorise Friends Provident International Limited to pass information including medical information to medical examiners and practitioners, underwriters, claims investigation companies, life insurance or reinsurance companies, data processors and to any company or agency appointed for these purposes. (These companies or agencies may be located in countries that do not have laws to protect your information. Friends Provident International Limited will remain responsible for making sure that the information is held securely.)
• I also agree Friends Provident International Limited may pass the information to third parties for the prevention of crime or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

9 • **I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess this application.** You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance on my life that I have applied for. I authorise those asked to provide medical and policy information when they see a copy of this consent form.

First (or only) Life
(who will also be the applicant if Part 10 not completed)

Signature

Date (ddmmyy)

Second Life
(who will also be the applicant if Part 10 not completed)

Signature

Date (ddmmyy)

* Application must be received by Friends Provident International Limited within six weeks of the date of signing

Only complete the following if Part 10 completed

First applicant (if applicable)

Signature

Date (ddmmyy)

Second applicant (if applicable)

Signature

Date (ddmmyy)

If signing on behalf of a Company or partnership please state in what capacity you are signing (eg Company Secretary)

Capacity

Capacity

Complete the following for all applications

Country where advice given

Country where application signed

Part 13 – Appointment of Third Party Payee as Beneficiary

You may use this section to nominate a beneficiary to receive the death benefits.
Important: Using this form may not be an effective solution if your objective is to reduce the inheritance tax payable by your estate on death. We recommend that you obtain legal advice.

*** Delete as appropriate**

To: Friends Provident International Limited

Subject to any future revocation or appointment, I/we* hereby appoint the following person/persons* as beneficiary in the share / shares* indicated below.

This appointment does not apply to any Critical Illness and Disability Benefit, Terminal Illness Benefit or Total and Permanent Disability Benefit if included in the policy.

Full name and address of the beneficiary	Share of benefit (%)

Certified identification and verification of residential address for each beneficiary will be required at the time of the claim.

In the event that at the time of any payment you are unable to contact the beneficiary, you should make enquiries of the following person / persons* for the purposes of locating the beneficiary:

Name of contact:	
Address:	
Telephone number:	

If no contact name is given, this will not affect the validity of this appointment. Names and details of other contact persons may be attached if desired.

I/We* confirm that I/we* have taken legal advice before signing this form or I/we* have elected not to do so.

I/We* also understand that the beneficiary appointment made on this form shall be revoked by any surrender assignment or disposal of the policy and by my death/the death of the survivor of us* if at my death/the death of the survivor of us* I am/we are* survived by other persons named as life assured on the schedule to the policy.

This form shall form part of the policy and the appointment is made in accordance with the relevant provision of the policy.

Signed (All joint policyholders must sign)

Signature Date	Signature Date
Signature Date	Signature Date

Accepted by Friends Provident International Limited on Date

Part 14 – Payment Details

Banker's standing order / telegraphic transfer

Most banks insist on completion of their own standing order form. Please contact your own bank for setting up your standing order after we have confirmed your premium amount.

Please ensure when setting up the standing order all premiums need to be paid **net of charges** to ensure the full premium amount is received by us.

Please forward a copy of the standing order form stamped with the official bank stamp.

Please take care to ensure the correct account is used on the standing order (see below for details)

Cheque / post dated cheques

Please make cheques payable to **Friends Provident International Limited**. These should be forwarded through your Financial Adviser, or alternatively can be sent directly to us at the address below.

Please do not forward cheques until Friends Provident International has confirmed your premium, following underwriting.

Please ensure all cheques are clearly referenced on the reverse with your policy number

Friends Provident International Limited
Building 6, Floor 5
Emaar Square
PO Box 215113
Dubai
UAE

This account can be used when paying for sterling premiums from any currency

The transfer amount should be written in sterling

Sterling

Bank: HSBC
Postal address: PO Box 421, Douglas,
Isle of Man,
British Isles, IM99 3AE
Account Name: Friends Provident
International Limited
Sort Code: 40-19-38
SWIFT/BIC Code: MIDLGB22
Sterling a/c no: 401938-22566621
Sterling IBAN: GB86MIDL40193822566621

This account can only be used for an AED premium plan, when paying from an AED account

Arab Emirates dirham

Bank: HSBC, Dubai
Postal address: PO Box 66
Dubai, UAE
Account Name: Friends Provident
International Limited
SWIFT/BIC Code: BBMEAEAD
AED a/c no: 025-171067-437
IBAN: AE610200000025171067437

These accounts can be used to pay for either US dollar premiums or Euro premiums from any currency (except AED – see next box)

The transfer amount should be written in either USD or Euro, depending on the premium currency

US dollar and euro

Bank: HSBC
Postal address: 27-32 Poultry, London EC2 2BX,
United Kingdom
Account Name: Friends Provident
International Limited
Sort Code: 40-05-15
SWIFT/BIC Code: MIDLGB22
USD a/c no: 400515-58980076
EUR a/c no: 400515-58980092
USD IBAN: GB42MIDL40051558980076
EUR IBAN: GB95MIDL40051558980092

This account can only be used for a US dollar premium plan, when paying from an AED account

The transfer should be written in AED amount, not in USD

Arab Emirates dirham

Bank: HSBC
Postal address: PO Box 66,
Dubai, UAE
Account Name: Friends Provident
International Limited
SWIFT/BIC Code: BBMEAEAD
USD a/c no: 025-171067-211
IBAN: AE202000000025171067211

Important: Before setting up your payment, please check you use the current AED to USD exchange rate to ensure the correct USD premium amount is paid.

Page left blank intentionally

Part 14 – Payment Details (continued)

Credit Card Authority

Available for sterling, US dollar and euro monthly and annual payments for terms of 2 years or more only.

This form supersedes any previous instructions held.

Please use BLOCK CAPITALS

I authorise Friends Provident International Limited, Royal Court, Castletown, Isle of Man, British Isles, IM9 1RA;
Telephone: +44(0) 1624 821212; Fax: +44(0) 1624 824405, to charge the premium below, to my credit card account for this insurance policy. This authorisation is to remain in effect until I cancel it by written notification to Friends Provident International Limited at least 30 days in advance of the intended date of cancellation.

Name of cardholder

Bank

Credit card number

Expiry date (mmyy)

☐ Mastercard ☐ VISA credit card ☐ Eurocard

with sum of (premium amount if known)

Please leave blank*

Currency

Collected on the (premium due date)

and on the same day until further notice ☐ monthly ☐ yearly

Please leave blank*

Address of credit card holder (as held by the card provider)

Signature

Date (ddmmyy)

IMPORTANT NOTES

1 Please note that debit cards cannot be accepted for premium payments.

2 Please note that some credit cards cannot be used outside their country of issue and therefore we strongly recommend that you contact your card issuer to ensure your card can be used in this instance.

* I understand that Friends Provident International Limited will complete these once the premium amount is finalised

Important information

The information given in this document is based on the understanding of Friends Provident International Limited of current United Arab Emirates and Isle of Man law and taxation practice, which may change in the future.

No liability can be accepted for any personal tax consequences of this scheme or for the effect of future tax or legislative changes.

All policyholders will receive the protection of the Life Assurance (Compensation of policyholders) Regulations 1991 of the Isle of Man, wherever their place of residence.

Whilst resident in the United Arab Emirates, complaints we cannot settle can be referred to the United Arab Emirates Insurance Authority or if you wish to the Financial Services Ombudsman Scheme for the Isle of Man.

If you are not resident in the United Arab Emirates or are no longer resident in the United Arab Emirates, complaints we cannot settle can be referred to the Financial Services Ombudsman Scheme for the Isle of Man.

Some telephone communications with the Company are recorded and may be randomly monitored.

LEGAL INTERPRETATION

International Protector Middle East is governed by the laws of the United Arab Emirates and all disputes relating to a policy shall be subject to the jurisdiction of the courts of the United Arab Emirates, except as otherwise expressly agreed by the parties in writing.

Friends Provident International Limited

Registered and Head Office: Royal Court, Castletown, Isle of Man, British Isles, IM9 1RA.
Telephone: +44(0) 1624 821 212 Fax: +44(0) 1624 824 405

Incorporated company limited by shares.
Registered in the Isle of Man, number 11494.
Authorised by the Isle of Man Insurance and Pensions Authority.
Provider of life assurance and investment products.

United Arab Emirates

Friends Provident International Limited
Dubai Branch
Emaar Square, Building 6, Floor 5,
PO Box 215113, Dubai, United Arab Emirates
Telephone: +9714 436 2800 Fax: +9714 438 0144
Email: dubaiservicing@fpinternational.com
Website: www.fpinternational.com/me

Registered in the United Arab Emirates as an insurance company (Registration No. 76).
Registered with the Ministry of Economy as a foreign company (Registration No. 2013): Registration date 19 April 2007.
Authorised by the United Arab Emirates Insurance Authority to conduct life assurance and funds accumulation operations.
Friends Provident International is a registered trade mark of the Friends Life group.

FRIENDS PROVIDENT INTERNATIONAL
فريندز بروفيدنت انترناشيونال

XIN35/A_ME 02.14 (40287)