



Application Form
Personal Income Protection Plan
Income Protection
from the original provider

Adviser Identification (Company Name) _____
Adviser Name: _____ FRN No: _____

Commission Style: Indemnity Non-indemnity

Adviser contact Tel. No: _____ Email Address: _____

Have you received advice from a Financial Adviser? Yes No

Have you received a quotation? Yes No

Quotation reference number: _____

Proposed date of commencement: If your application is accepted at standard terms when should cover commence?

Immediately On date dd mm yyyy To be advised

Personal Income Protection Plan Application

(For completion by the Applicant)

Important notes: please read carefully

You must answer and complete all of the questions. If your answer is 'Yes' to any of them, then full details must be provided. Remember to sign both the declaration and the direct debit mandate.

Your financial adviser will be happy to help you complete this form. However, it is your responsibility to read the answers given and check that they record accurately what you have said.

Please state who has completed this form: _____

Please take care to include any material fact in your application which could affect the payment of any claim, as failure to do so may result in any monies paid to the Society together with any claims made on the funds thereof being forfeited. A material fact is one that is likely to influence the assessment and acceptance of your application. If you are in any doubt as to whether a fact is material, you should disclose it.

A copy of your completed application is available on request and the Society's Memorandum, Rules and Schedule pertaining to your application can be obtained by visiting our website: www.holloway.co.uk/members/documents/

Section 1: Personal Details

Title _____ Surname _____
First Name(s) _____
Address _____
Address _____ Town/City _____
County _____ Postcode _____
Daytime Tel. No _____ Evening Tel. No _____ Mobile No _____
Email _____

Gender Male Female

Date of birth dd mm yyyy Age

Place of birth _____

If your place of birth is not in the UK, how long have you been permanently resident here? years
(The Society will not accept applicants who have not been resident and registered with a GP in UK for the last 36 months)

Section 1: continued

Name and address of your Doctor with whom you are currently registered

Doctor's Name _____

Address _____

Address _____ Town/City _____

County _____ Postcode _____

Tel. No _____

How long have you been registered with this doctor? Years Months

If less than 6 months, please give details of your previous doctor.

Doctor's Name _____

Address _____

Address _____ Town/City _____

County _____ Postcode _____

Tel. No _____

Have you used any tobacco products or nicotine substitutes within the last 12 months? Yes No

If you have given up in the last 12 months or only smoke occasionally you must answer this question 'yes'

If 'Yes' state **type** and **daily amount** _____

We may ask you to undergo a simple test to determine your smoking habits before we start your plan.

In a typical week how much of the following do you drink?

Pints of strong beer/cider/lager 4.6% vol or more (e.g. Stella/Kronenburg/Strongbow/Blackthorn)

Pints of ordinary beer/cider/lager 4.5% vol or less (e.g. Carlsberg/Fosters/Guinness/Tetley's/Magner's)

Bottles of wine

Glasses of wine

Small pub measures of spirits or liqueurs

Pre mixed spirits (e.g. Smirnoff Ice/Reef/WKD/Bacardi Breezer)

Have you ever been recommended by your GP or any other medical practitioner to reduce your intake of cigarettes or alcohol? Yes No

If 'Yes', details _____

Please state height _____ft _____ins or _____cms

Please state weight _____st _____lbs or _____kgs

Has there been any gain or loss in your weight within the last 12 months? Yes No

If 'Yes', details _____

Section 2: Occupations

What is your main occupation? _____ Occupational Class _____

Are you employed? self employed? both employed/self employed?

What type of industry do you work in? _____

If employed for **how long** and **how much** will you be paid by your employer in the event of sickness or accident?

Do you have a secondary occupation e.g. TA or reservist? Yes No

If yes please provide details _____

Do any of the following form part of your jobs? Please advise percentage of time spent and details:

Administration _____ % _____

Driving include annual mileage _____ % _____ Mileage _____

Driving HGV include annual mileage _____ % _____ Mileage _____

Driving LGV include annual mileage _____ % _____ Mileage _____

Use of machinery/tools _____ % _____

(include type used) _____

Physical or manual work _____ % _____

Work at heights over 40ft _____ % _____

Work underground or underwater _____ % _____

Work with hazardous materials _____ % _____

How many hours on average do you work each week?

How long have you been in your current employment? Years Months

If less than 5 years please describe the duties of your previous occupation.

Duties _____

Do you pay Income Tax in the UK? Yes No

If 'No', please provide details _____

What is your total annual income from any of the following sources:

Self employed £ _____

(This is your share of pre tax profit after deduction of trading expenses)

Employed £ _____ (Pre tax earnings for PAYE purposes)

Does your income include any variable items? Yes No

If 'Yes' please tick whichever of the following apply and the percentage of your income this represents

Dividends? Yes percentage Bonuses? Yes percentage

Overtime? Yes percentage Commission? Yes percentage

If Dividends form part of your income for how long will they be declared should you be unable to work owing to illness or an accident?

Are you employed as a director of a limited company? Yes No

If 'Yes' how many shareholder directors are there within the company?

In the past 5 years have you lived or worked outside the EU, USA or Canada, Australia or New Zealand? Yes No

Do you have any intention of working, travelling or residing outside the UK? Yes No

If you have answered 'Yes' to either question complete travel/residence questionnaire, available online or by request.

Do you, or do you intend to:

A) Engage in aviation other than as a fare paying passenger? Yes No

B) Engage in active sports of any kind? Yes No

If 'Yes' please give further details and frequency of activity _____

Section 3: Benefit Requirements

Benefit required £ _____ per month / £ _____ per week Monthly premium £ _____

Cover type: Do you require indexation/escalation of benefit? Yes No

Deferred Period 4 week 8 week 13 week 26 week 52 week

Please state the age between 50 years and 70 years inclusive at which you wish this plan to cease

Section 4: Other Insurances

Have you applied to any other company for Income Protection insurance, or are you about to do so? Yes No

If 'Yes' please state company and details _____

Has any insurance company for Health or Life Insurance declined your application or accepted you on special/revised terms? Yes No

If 'Yes' please state company and reason for decision _____

Have you got existing Income Protection insurance? Yes No

If 'Yes' please state company, level of cover, deferment period _____

Section 4: continued

Are you cancelling any existing Income Protection insurance cover when this plan commences? Yes No

Have you ever made claims on Income Protection insurance currently or previously held? Yes No

If 'Yes' please give details _____

Section 5: Your Health and Medical History

All answers will be treated in strict confidence.

Please consult your doctor if you are unsure that you will be able to remember all health details that may be relevant.

If you answer 'Yes' to **ANY** question, please use the boxes provided in section 6 to give complete and full details. Include the date(s), treatment and period(s) off work, and say whether there has been a complete recovery or any recurrence of the problem.

Part 1

a) Have you seen your doctor within the last 12 months? Yes No

b) Are you currently suffering any symptoms for which you may consult any doctor or other medical practitioner? Yes No

c) Are you receiving any treatment either regular or occasional, e.g. tablets, medicines or injections, awaiting any medical or surgical consultation, test or investigation or are you awaiting the results of a consultation? Yes No

d) Have you tested positive for HIV/AIDS or Hepatitis B or C or are you awaiting the result of such a test? (routine testing for blood donation purposes may be ignored) Yes No

e) Have you ever used drugs other than as approved or prescribed by a medical practitioner? Yes No

f) Have either of your parents, brothers or sisters before the age of 65, died or suffered from: Heart disease, stroke, cancer, diabetes, multiple sclerosis, Huntington's disease, polycystic kidney disease, polyposis of the colon, raised cholesterol or any other hereditary disorder? Yes No

If 'Yes' please give details _____

Part 2

Have you during the last five years suffered from or consulted your doctor or any other medical practitioner (e.g. chiropractor, osteopath or physiotherapist) for any of the following?

a) Asthma, bronchitis or any other respiratory problems? Yes No

b) High blood pressure, raised cholesterol, chest pain or irregular heart beat? Yes No

- c) Psoriasis, eczema, dermatitis, moles or any other skin condition, to include growths, cysts or lumps? Yes No
- d) Anxiety, stress or insomnia? Yes No
- e) Back pain, sciatica, neck, knee, elbow or wrist pain? Yes No
- f) Any other joint pain, to include disorders of the muscles or tendons? Yes No
- g) Epilepsy, fainting, fits or blackouts? Yes No
- h) Numbness, tingling, loss of feeling or sensation, dizziness, headaches, migraine impairment of balance or coordination? Yes No
- i) Any disorder of the blood to include anaemia? Yes No
- j) Thyroid disorder and any other hormone imbalance? Yes No
- k) Kidney, liver, prostate or bladder disorder to include blood or protein in the urine and urinary tract infections? Yes No
- l) Any injury or accident resulting in medical treatment or time off work? Yes No
- m) Tested positive or been treated for any disease which was transmitted sexually? Yes No
- n) Been exposed to the risk of HIV infection? Yes No

Additional question for female applicants:

- o) Any gynaecological disorder or changes to your breast(s)? Yes No

Part 3

Have you at **any** time ever had medical investigation or consultation, advice, operation or treatment for any of the following?

- a) Heart attack, angina, heart murmur or any disease or abnormality of your heart? Yes No
- b) Stroke, transient ischaemic attack, brain haemorrhage or injury? Yes No
- c) Any disease or disorder affecting your arteries to include arterial disease of the legs and aorta? Yes No
- d) Tumours, cancers, lymphoma or any malignant lump, growth or lesion, including leukaemia or Hodgkin's disease? Yes No
- e) Any type of arthritis, rheumatism, any chronic or recurrent neck, back, spinal, joint or muscular problems? Yes No
- f) Persistent or recurrent malaise or tiredness, myalgic encephalomyelitis (M.E), post viral fatigue or chronic fatigue syndrome? Yes No
- g) Depression, personality, mood or eating disorder, mental illness or breakdown or psychiatric condition? Yes No
- h) Stomach ulcer, hernia, colitis or any chronic or recurrent disorder of the digestive system e.g. oesophagus, duodenum, stomach, bowels? Yes No
- i) Paralysis, multiple sclerosis or any other disorder of the central nervous system? Yes No
- j) Permanent or progressive defect in sight, optic or retrobulbar neuritis (not long or short sight which is corrected by lenses), permanent or progressive hearing loss or tinnitus? Yes No
- k) Diabetes, or impaired glucose tolerance? Yes No

Section 6: Further Information (medical questionnaire)

For confidentiality you may send your health details on a separate piece of paper direct to our Chief Medical Officer at Holloway House, 71 Eastgate Street, Gloucester, GL1 1PW. Please state your full name and date of birth.

You should also sign and date these details. Please tick the box if you decide to do this.

Where you have ticked 'Yes' to any question in Section 5, please give a full and definite answer next to each question below. If there is not sufficient space, please continue on a separate piece of paper.

Disorder(s)

1	<hr/> <hr/>
2	<hr/> <hr/>
3	<hr/> <hr/>

Date of Disorder(s) and duration

1	<hr/> <hr/>
2	<hr/> <hr/>
3	<hr/> <hr/>

Treatment

1	<hr/> <hr/>
2	<hr/> <hr/>
3	<hr/> <hr/>

Result of investigations

1	<hr/> <hr/>
2	<hr/> <hr/>
3	<hr/> <hr/>

Time off work and when

1	<hr/> <hr/>
2	<hr/> <hr/>
3	<hr/> <hr/>

Note: To support your application please provide any copies of medical reports which may be available to yourself. This will ensure that the processing of your application is dealt with as speedily as possible.

Data Protection Notice

The information provided in the application will be used to carry out an initial risk assessment of the application and to collect any medical reports or information required by Holloway Friendly to establish the terms for your application.

On completion of the collection of information it will be used to set up and administer the plan. If your application does not proceed, Holloway Friendly may hold a record of the application for a limited time period. A copy of the application form and any supporting information, including medical reports, may be given to a reassurance company if the risk is shared with the reassurance company. We may write to your GP if in our opinion a condition is noted at any medical examination, of which your GP may not be aware.

Information and where appropriate copies of correspondence may be given to your financial adviser to enable them to give you advice. This will not include medical information.

Any medical information, which is provided in connection with your application, will be used only for underwriting and claims purposes.

If you would like to request a copy of the information held about you, please write to the Holloway Friendly Data Protection Co-ordinator. A fee may be charged for providing information. The information that you have supplied will be kept confidential and will not be disclosed to any other party without your consent, unless it is lawful to do so.

Some services are provided to Holloway Friendly by third parties such as underwriting and claims control or obtaining compliance or regulatory advice, which warrant the disclosure of more than just your basic contract details. You agree that personal information held by Holloway Friendly may be disclosed on a confidential basis, and in accordance with the Data Protection Act 1998, to any such third parties. You also agree that this information may be transferred electronically, e.g. email and you agree that ourselves, or any such third party, may contact you in future by any means of communication which we consider appropriate at the time.

Disclosure

This form is an application for Income Protection insurance. Its purpose is to obtain all the facts necessary to fully assess your case. A copy of your completed application is available on request and the Society's Memorandum, Rules and schedule pertaining to your application can be obtained by visiting our website: www.holloway.co.uk/documents/

You must answer all questions honestly and completely. Therefore if you are in any doubt whether to disclose a fact you should give its full details on the form.

Failure to disclose all the facts could mean that Holloway Friendly will refuse to pay any claim on your plan and you could also lose the premiums you have made.

Continuing Duty to Disclose

You must advise us in writing if there is any change in your circumstances between completing this form and the start date of the plan. Please advise of any changes to the following:

- Your health details
- Family history
- Occupation
- Earnings
- Employment status
- Travel or residence
- Hazardous pastimes
- Alcohol consumption
- Smoking habit

Disclosures to any of the questions medical or otherwise are of equal importance and failure to advise us may result in non payment of a claim.

You can contact Underwriting at Holloway Friendly:-

On: 01452 782760, Monday to Friday 9.00am until 5.00pm, or

Fax on: 01452 386859, or

Email at: underwriting@holloway.co.uk or

Write to: Underwriting, Holloway Friendly, Holloway House, 71 Eastgate Street, Gloucester, GL1 1PW.

This application form will form the basis of the contract with Holloway Friendly.

Access to Medical Reports Act

To consider your application we may have to obtain a medical report from a doctor who has cared for you. The Access to Medical Reports Act 1988 or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 gives you certain legal rights over these reports.

Briefly your rights are as follows:

1. Before we can apply for a medical report from a doctor who has cared for you, we need your agreement. You can refuse but in this case we will not be able to make any offer to cover you.
2. You can ask to see a report before your doctor sends it to our Chief Medical Officer or you can ask your doctor to see a copy of the report for up to six months after it has been sent to us.
3. If you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your doctor will not agree to this, you may attach a statement of your own.

Your doctor does not have to let you see the report if he or she believes it is not in the interests of your health, or if the interests of other people have to be considered. Once you have seen the report your doctor cannot return it to us unless you agree.

If we need a report and you have said you want to see it before it is returned to us, we will write to let you know. You will then have 21 days to contact the doctor to arrange to see the report. After this period the doctor will be free to return the report.

Genetic Testing

You do not need to give information about any genetic test result you have had should this application together with any other insurance policies you have are within the following limits:

£500,000 or less for Life Assurance

£300,000 or less for Critical Illness or Long Term Care insurance

£30,000 annual benefit for Income Protection

Above these limits you may need to give information about certain test results when applying for insurance. Only genetic test results, which have been approved, by the Government's Genetics and Insurance Committee will be used.

You must however give information if you have a family history or symptoms of a genetic condition. It may be to your benefit to disclose if you have had a negative genetic test for such a condition.

Declaration and Consent

I hereby apply for membership of Holloway Friendly. I declare that I have included any material fact in this application which would affect the payment of any claim as failure to do so may result in any monies paid to Holloway Friendly, together with any claim made on the funds thereof, being forfeited. I confirm receipt, have read and understand the appropriate Key Features document of the plan.

I also fully understand in the event of a claim, my limitations to benefit entitlement as stated in the Key Features document.

I have read and understood the Data Protection Notice. I agree that my personal information (including sensitive data) may be used for the purposes described.

I declare that to the best of my knowledge and belief the answers I have given (whether in my handwriting or not) are true and complete. I confirm I have read and understand the Disclosure and Continuing Duty to Disclose notes in this form.

I am aware of my legal rights under the Access to Medical Reports Act 1988 or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

I agree that Holloway Friendly or any nominated Insurance Company may ask for medical information from any doctor who at any time has attended me about anything that affects my physical or mental health or ask for information, including medical reports, from any insurance office to which a proposal has been made on my life and I authorise the giving of such information.

I also agree that this consent allows the insurer to obtain a medical report at any time during the lifetime of the plan and after my death to support any claim on the plan.

I agree that a copy of this application can be treated as the original for all purposes.

I understand that if I have failed to give correct answers to any questions in this application then the plan may be cancelled.

I do not wish to see this report before it is sent to Holloway Friendly or any nominated Insurance Company.

If you wish to see the report please tick the box. []

Signature

Date



Instruction to your Bank or Building Society to pay by Direct Debit



Please fill in the whole form and send to The Original Holloway Friendly Society Limited, Holloway House, 71 Eastgate Street Gloucester GL1 1PW

Name and full postal address of your Bank or Building Society

To: The Manager Bank/Building Society
Address
Postcode

Name(s) of Account Holder(s)

[]

Bank/Building Society account number

[]

Branch Sort Code

[]

Originator's Identification Number

9 3 0 4 3 9

Reference Number

[]

Instruction to your Bank or Building Society.

Please pay The Original Holloway Friendly Society Limited Direct Debits from the account detailed in this Instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with The Original Holloway Friendly Society Limited and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date

Banks and Building Societies may not accept Direct Debit Instructions from some types of account

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme.
The efficiency and security of the scheme is monitored and protected by your own Bank or Building Society.
If the amounts to be paid or the payment dates change, The Original Holloway Friendly Society Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed.
If an error is made by The Original Holloway Friendly Society Limited or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.





Holloway House
71 Eastgate Street
Gloucester
GL1 1PW

tel: 01452 526238
fax: 01452 386859
email: mail@holloway.co.uk
web: www.holloway.co.uk

technician b
hairstylists managing d
sales manager sh
counsellor

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Founded in 1880

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