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|  | Albany House, 14 Shute End Wokingham, Berks RG40 1BJ0118 974 0222 |

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| **PROTECTION DATA CAPTURE FORM** |

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| 1. **ABOUT THE PEOPLE COVERED**
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|  | **Person 1** | **Person 2** |
| **Title** | Mr / Mrs / Miss / Ms / Dr | Mr / Mrs / Miss / Ms / Dr |
| **Surname** |  |  |
| **First Name** |  |  |
| **Middle Names** |  |  |
| **Date of Birth** |  |  |
| **Sex**  |  |  |
| **Marital Status** (indicate with  or Y) |  | **Married** |  | **Married** |
|  | **Living together as partners** |  | **Living together as partners** |
|  | **Divorced** |  | **Divorced** |
|  | **Widowed** |  | **Widowed** |
|  | **Single** |  | **Single** |
|  | **Separated** |  | **Separated** |
|  | **Civil partnership** |  | **Civil partnership** |
|  | **Surviving civil partner** |  | **Surviving civil partner** |
| **Relationship to Person 1 / 2**(indicate with  or Y) |  | **Wife** |  | **Wife** |
|  | **Husband** |  | **Husband** |
|  | **Partner** |  | **Partner** |
|  | **Cohabitant** |  | **Cohabitant** |
|  | **Common law spouse** |  | **Common law spouse** |
|  | **Business partner** |  | **Business partner** |
|  | **Other** |  | **Other** |
| If Other, please give full details: |  |  |
| **Home Address** |  |  |
|  | **House name** |  |  |
|  | **House number** |  |  |
|  | **Street name** |  |  |
|  | **Town / City** |  |  |
|  | **County** |  |  |
|  | **Postcode** |  |  |
|  | **Phone daytime** |  |  |
|  | **Phone evening** |  |  |
|  | **Mobile** |  |  |
|  | **Email** |  |  |
| 1. **ABOUT THE PEOPLE COVERED** continued
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|  | **Person 1** | **Person 2** |
| **Have you smoked in the last 12 months?**A smoker is anyone who has used any form of tobacco or nicotine replacement products in the last 12 months.If you answer No, the provider may carry out tests to check that you are a non-smoker. | No / Yes | No / Yes |
| If Yes, please tell us how much you smoke a day: | If Yes, please tell us how much you smoke a day: |
| Cigarettes a day |  | Cigarettes a day |  |
| Cigars a day |  | Cigars a day |  |
| Pipes a day |  | Pipes a day |  |
| Other |  | Other |  |
| **How old were you when you started smoking?** |  |  |
| **ONLY ANSWER THE FOLLOWING QUESTION IF YOU HAVE NOT SMOKED IN THE LAST 12 MONTHS** |
| **Have you ever smoked any form of tobacco products?**A smoker is anyone who has used any form of tobacco or nicotine replacement products in the last 12 months.If you answer No, the provider may carry out tests to check that you are a non-smoker. | No / Yes | No / Yes |
| If Yes, please tell us how much you smoke a day: | If Yes, please tell us how much you smoke a day: |
| Cigarettes a day |  | Cigarettes a day |  |
| Cigars a day |  | Cigars a day |  |
| Pipes a day |  | Pipes a day |  |
| Other |  | Other |  |
| **How old were you when you started smoking?****When did you stop smoking?** |  |  |
|  |  |
| **Have you ever had an application on your life accepted on special terms, deferred or declined?** | No / Yes | No / Yes |

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| 1. **YOUR JOB AND LIFESTYLE**
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|  | **Person 1** | **Person 2** |
| **In which country are you permanently resident?**(indicate with  or Y) |  | UK |  | UK |
|  | Jersey |  | Jersey |
|  | Guernsey |  | Guernsey |
|  | Isle of Man |  | Isle of Man |
|  | Other |  | Other |
| If Other, please give full details: |  |  |
| **In the next 6 months, will you be moving from the country in which you are permanently resident?** | No / Yes | No / Yes |
| **In the last 2 years, have you lived outside the UK, Channel Islands or Isle of Man for more than 6 months?** | No / Yes | No / Yes |
| **Other than holidays of less than 3 months, have you any intention of going outside the UK, Channel Islands or Isle of Man?** | No / Yes | No / Yes |
| **What is your current job?** |  |  |
| **Do you work in one of the following industries?** | No / Yes | No / Yes |
| Armed ForcesAviationConstructionDemolition Diving | DocksMerchant Marine FishingMining/Tunnelling | Oil/Gas Rigs OffshoreQuarryingRailwaysShip Building or Repair |
| **What is your employment status?**(indicate with  or Y) |  | Salaried employee |  | Salaried employee |
|  | Self-employed |  | Self-employed |
|  | House Person |  | House Person |
|  | Student |  | Student |
|  | Retired |  | Retired |
|  | Not Employed |  | Not Employed |
| **Does your job involve hazardous duties?**e.g. working at heights, working with explosives or handling asbestos. | No / Yes | No / Yes |
| **Are you a member of the Territorial Army (TA) or Armed Forces reservists?** | No / Yes | No / Yes |
| **Approximately what percentage of time do you spend each week on these activities?**A breakdown of your activities is still needed if you are a house person, student, retired or not employed. This information is only needed if you are applying for Critical Illness Cover, Life or Critical Illness Cover, Income Cover or Payment Cover for Sickness |  |  |
| **Administrative or office duties** |  | % |  | % |
| **Manual or physical work** |  | % |  | % |
| **Driving (excluding commuting)** |  | % |  | % |
| **Total** |  | 100% |  | 100% |
| **If your work includes driving, what is your annual mileage?** |  |  |
| **How many hours a week do you work on average?**Please exclude commuting and on-call time. |  |  |
| **What are your gross annual earnings from your employment or self-employment?** |  |  |

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| 1. **YOUR JOB AND LIFESTYLE** continued
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|  | **Person 1** | **Person 2** |
| **Do you take part in any hazardous leisure activity?** e.g. private aviation, diving, yachting or sailing, mountaineering or rock-climbing, motor sports, caving or potholing, parachuting, hang-gliding. Do not include one-off events such as parachute jumps for charity. | No / Yes | No / Yes |
| If Yes, please give full details |
|  |  |
| **What is your height?** |  | **feet** |  | **inches** |  | **feet** |  | **inches** |
|  | **m** |  | **cm** |  | **m** |  | **cm** |
| **What is your weight?** |  | **stones** |  | **lbs** |  | **stones** |  | **lbs** |
|  | **kilos** |  |  |  | **kilos** |  |  |
| **In the last 3 months, has your weight increased or decreased by 7lbs (3kgs) or more, for reasons other than pregnancy?** | No / Yes | No / Yes |
| If Yes, please give full details |
|  |  |
| **How many units of alcohol do you drink in an average week?**1 pint of beer = 2 units;1 glass or wine (175ml) = 2 units1 measure of spirits = 1 unit |  | **Units** |  | **Units** |
| **Have you ever been given medical advice to reduce your alcohol intake or had or been advised to have any form of treatment or counselling relating to your alcohol consumption?** | No / Yes | No / Yes |
| **Have you ever used illegal or recreational drugs or injected non-prescription drugs?**e.g. cocaine, heroin, cannabis, ecstasy. | No / Yes | No / Yes |

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| 1. **YOUR HEALTH**
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|  | **Person 1** | **Person 2** |
| **1. Before the age of 60, have any of your parents or brothers or sisters had:** | No / Yes | No / Yes |
| **Alzheimer’s disease****Cancer****Cardiomyopathy****Diabetes****Haemochromatosis****Heart disease** (including heart attack or angina) **Huntington’s disease** | **Motor Neurone Disease****Multiple sclerosis****Muscular dystrophy****Parkinson’s disease****Polycystic kidney disease****Stroke****Or any hereditary disorder?** |
| **2. Have you ever tested positive, or are you awaiting test results for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or hepatitis B or C?**If the result was negative, the fact that you had an HIV test will not itself have any effect on your acceptance terms for insurance. | No / Yes | No / Yes |
| **3. In the last 5 years have you had any exposure to the risk of Human Immunodeficiency Virus (HIV) infection?**This can be caught through unsafe sex, intravenous drug abuse or blood transfusions or surgery undertaken outside the EU. | No / Yes | No / Yes |
| **4. In the last 5 years have you tested positive or been treated for any disease that was transmitted sexually?** | No / Yes | No / Yes |
| **For questions 5 to 14, do you have, or have you ever had, any of the following?** |
| **5. Multiple sclerosis, Parkinson’s disease, paralysis, epilepsy, Alzheimer’s disease, dementia or cerebral palsy** | No / Yes | No / Yes |
| **6. Any neurological complaint, numbness, dizziness, involuntary shaking, loss of feeling, tingling of the limbs or face, or temporary loss of muscle power or co-ordination** | No / Yes | No / Yes |
| **7. Cancer, tumour, leukaemia, Hodgkin’s disease, lymphoma, melanoma or any malignant condition** | No / Yes | No / Yes |
| **8. Irregular heartbeat, palpitations, heart murmur or heart disease including angina, heart attack or chest pains** | No / Yes | No / Yes |
| **9. Stroke, transient Ischaemic Attack (TIA), brain haemorrhage or brain injury** | No / Yes | No / Yes |
| **10. Diabetes or sugar in the urine** | No / Yes | No / Yes |
| **11. Any nervous or mental disorder****e.g. anxiety, stress, depression, schizophrenia, suicide attempt.** | No / Yes | No / Yes |
| **12. Any hereditary disorder** | No / Yes | No / Yes |
| **13. Any disorder of the eyes or blurred or double vision, not fully corrected by glasses or contact lenses****e.g. glaucoma, optic neuritis.** | No / Yes | No / Yes |
| **ONLY ANSWER THIS QUESTION IF YOU ARE MALE****14. Any prostate enlargement or abnormal PSA (Prostate specific antigen), testicular or urinary problems**e.g. undescended testicle, difficult or urgency in passing urine. | No / Yes | No / Yes |
| 1. **YOUR HEALTH** continued
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|  | **Person 1** | **Person 2** |
| **For questions 15 to 27, in the last 5 years have you had any of the following?** |
| **15. High blood pressure, or** * **taken, or been advised to take, treatment for high blood pressure or**
* **had, or been advised to have your blood pressure monitored (other than as part of pregnancy)**
 | No / Yes | No / Yes |
| **16. High cholesterol, or** * **taken, or been advised to take, treatment for raised cholesterol, or**
* **had, or been advised to have, your cholesterol levels monitored**
 | No / Yes | No / Yes |
| **17. Any cyst, growth, lump or swelling** | No / Yes | No / Yes |
| **18. Any mole or freckle that has changed in colour or appearance, bled, become painful or itchy, or increased in size** | No / Yes | No / Yes |
| **19. Asthma, bronchitis, pneumonia, emphysema or other lung disorder** | No / Yes | No / Yes |
| **20. Any disorder of the digestive system, gall bladder, stomach, bowel or liver**e.g. gastric ulcer, duodenal ulcer, hepatitis, jaundice, colitis, Crohn’s disease, hernia, irritable bowel syndrome. | No / Yes | No / Yes |
| **21. Any disorder of the thyroid** | No / Yes | No / Yes |
| **22. Any disorder of the kidneys or bladder**e.g. blood or protein in the urine or multiple urinary infections | No / Yes | No / Yes |
| **23. Any fit or blackout** | No / Yes | No / Yes |
| **24. Any disorder of the muscles, bones, joints or limbs**e.g. arthritis, rheumatoid arthritis, gout | No / Yes | No / Yes |
| **25. Any disorder of the back or neck** e.g. slipped disc | No / Yes | No / Yes |
| **26. Any disorder of the skin or ear** | No / Yes | No / Yes |
| **27. Any disorder of the blood** e.g. anaemia | No / Yes | No / Yes |
| **ONLY ANSWER THIS QUESTION IF YOU ARE FEMALE****28. Any biopsy or ultrasound of the breast, uterus, cervix or ovary, or any abnormal cervical smear or mammogram.**You do not need to tell us about testing as a result of pregnancy. | No / Yes | No / Yes |
| **29. Are you currently certified by a doctor as unfit for work?** | No / Yes | No / Yes |
| **30. Are you currently experiencing any symptoms or complaints for which you have not consulted a doctor?** | No / Yes | No / Yes |
| **31. Are you currently waiting, or been advised to seek, any medial or surgical consultation or follow-up?** | No / Yes | No / Yes |
| **32. In the last 5 years, other than for the conditions you have already told us about, have you*** **attended any other medical appointment,**
* **taken any other test or medication, or**
* **received any other treatment?**
 | No / Yes | No / Yes |
| 1. **ADDITIONAL QUESTIONS**
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| Your advisor will be asked for this information when applying online on your behalf. Sometimes the questions on this form many not match exactly the questions online. Your adviser may still need to contact you for further information before sending your application to Bright Grey.**If you answered Yes to question 1 in section C please also answer these questions.** |
|  | **Person 1 – Condition 1** | **Person 2 – Condition 1** |
| **What is the name of the first condition that any of your parents, brothers or sisters have suffered from, before the age of 60?** |  |  |
| **How many of your parents, brothers or sisters have had this condition?** |  |  |
| **For each relative with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.** | relative 1 |  | relative 1 |  |
| age at diagnosis |  | age at diagnosis |  |
| relative 2 |  | relative 2 |  |
| age at diagnosis |  | age at diagnosis |  |
| relative 3 |  | relative 3 |  |
| age at diagnosis |  | age at diagnosis |  |
| **If you have had any other relatives that have been diagnosed with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.** |  |  |

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|  | **Person 1 – Condition 2** | **Person 2 – Condition 2** |
| **What is the name of the first condition that any of your parents, brothers or sisters have suffered from, before the age of 60?** |  |  |
| **How many of your parents, brothers or sisters have had this condition?** |  |  |
| **For each relative with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.** | relative 1 |  | relative 1 |  |
| age at diagnosis |  | age at diagnosis |  |
| relative 2 |  | relative 2 |  |
| age at diagnosis |  | age at diagnosis |  |
| relative 3 |  | relative 3 |  |
| age at diagnosis |  | age at diagnosis |  |
| **If you have had any other relatives that have been diagnosed with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.** |  |  |

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| 1. **ADDITIONAL QUESTIONS** continued
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|  | **Person 1 – Condition 1** | **Person 2 – Condition 1** |
| **What is the name of the medical condition or injury that you have had or currently have?** |  |  |
| **When did your symptoms start?** |  |  |
| **How often do you have the symptoms?**(indicate with  or Y) |  | **Daily** |  | **Daily** |
|  | **Weekly** |  | **Weekly** |
|  | **Monthly** |  | **Monthly** |
|  | **Once or twice a year** |  | **Once or twice a year** |
|  | **No longer have symptoms** |  | **No longer have symptoms** |
| **If the symptoms have stopped, when was the last time you had symptoms of this condition?**Please give a date. |  |  |
| **Have you had any surgery, investigations or tests for this condition?** | No / Yes | No / Yes |
| If Yes, please give full details |
|  |  |
| **Do you expect or have you been advised to have surgery, tests or investigations including any hospital referrals, for this condition?** | No / Yes | No / Yes |
| If Yes, please give full details |
|  |  |
| **What was the treatment prescribed?** |  |  |
| **Is it still continuing?** | No / Yes | No / Yes |
| **How many days have you been off work because of this condition?** |  | days |  | days |
| **Which of the following best describes the severity of your condition?**(indicate with  or Y) |  | **Fully recovered with no remaining disability** |  | **Fully recovered with no remaining disability** |
|  | **Ongoing condition with no restrictions of daily activities or mobility** |  | **Ongoing condition with no restrictions of daily activities or mobility** |
|  | **Mild symptoms with infrequent restriction of daily activities or mobility** |  | **Mild symptoms with infrequent restriction of daily activities or mobility** |
|  | **Severe symptoms with infrequent restriction of daily activities or mobility** |  | **Severe symptoms with infrequent restriction of daily activities or mobility** |
|  | **Daily activities and tasks significantly restricted** |  | **Daily activities and tasks significantly restricted** |

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| 1. **ADDITIONAL QUESTIONS** continued
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|  | **Person 1 – Condition 2** | **Person 2 – Condition 2** |
| **What is the name of the medical condition or injury that you have had or currently have?** |  |  |
| **When did your symptoms start?** |  |  |
| **How often do you have the symptoms?**(indicate with  or Y) |  | **Daily** |  | **Daily** |
|  | **Weekly** |  | **Weekly** |
|  | **Monthly** |  | **Monthly** |
|  | **Once or twice a year** |  | **Once or twice a year** |
|  | **No longer have symptoms** |  | **No longer have symptoms** |
| **If the symptoms have stopped, when was the last time you had symptoms of this condition?**Please give a date. |  |  |
| **Have you had any surgery, investigations or tests for this condition?** | No / Yes | No / Yes |
| If Yes, please give full details |
|  |  |
| **Do you expect or have you been advised to have surgery, tests or investigations including any hospital referrals, for this condition?** | No / Yes | No / Yes |
| If Yes, please give full details |
|  |  |
| **What was the treatment prescribed?** |  |  |
| **Is it still continuing?** | No / Yes | No / Yes |
| **How many days have you been off work because of this condition?** |  | days |  | days |
| **Which of the following best describes the severity of your condition?**(indicate with  or Y) |  | **Fully recovered with no remaining disability** |  | **Fully recovered with no remaining disability** |
|  | **Ongoing condition with no restrictions of daily activities or mobility** |  | **Ongoing condition with no restrictions of daily activities or mobility** |
|  | **Mild symptoms with infrequent restriction of daily activities or mobility** |  | **Mild symptoms with infrequent restriction of daily activities or mobility** |
|  | **Severe symptoms with infrequent restriction of daily activities or mobility** |  | **Severe symptoms with infrequent restriction of daily activities or mobility** |
|  | **Daily activities and tasks significantly restricted** |  | **Daily activities and tasks significantly restricted** |

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| 1. **YOUR GP DETAILS**
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|  | **Person 1** | **Person 2** |
| **Your GP**If you need to check the GP’s address details, please do to **www.click-for-health.com**. If you do not give us their full name and address, it could delay your application.We may not always contact your GP to ask for more medical information so please make sure you give us all of the information we ask for when filling in your application. | **GP name** |  | **GP name** |  |
| **surgery name** |  | **surgery name** |  |
| **surgery address** |  | **surgery address** |  |
| **postcode** |  | **postcode** |  |
| **phone** |  | **phone** |  |
| **fax** |  | **fax** |  |
| **email** |  | **email** |  |
| **Have you been with this GP for less than 6 months?** | No / Yes | No / Yes |
| If Yes, please give us your previous GP’s name and address |
| **GP name** |  | **GP name** |  |
| **surgery name** |  | **surgery name** |  |
| **surgery address** |  | **surgery address** |  |
| **postcode** |  | **postcode** |  |

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| 1. **PAYMENT DETAILS**
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|  |  | **Person 2** (only if paying separately) |
| **Please tell us when you would like the plan to start** (indicate with  or Y)For a joint life application your plan will not start until the provider has accepted both people covered for all covers. |  | **Immediately the provider accepts the application** |  | **Immediately the provider accepts the application** |
|  | **I will tell you later** |  | **I will tell you later** |
|  | **On the date I tell you below** |  | **On the date I tell you below** |
|  |  |
|  |
| **How would you like to pay?** (indicate with  or Y)Depending on the start date of your plan, the first payment may not be collected on the day you choose. The provider will write to you before they collect the first payment. |  | **Monthly by direct debit** |  | **Monthly by direct debit** |
| Please tell us the day of the month between the 1st and 28th you would like the provider to collect your payment: |
|  |  |
|  | **Yearly by direct debit** |  | **Yearly by direct debit** |
|  |
| **Account details for direct debit payments** |  |  |  |  |
|  | Name of account holder |  |  |
|  | Sort code |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Account number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Bank Address |  |  |

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| **Data Protection Notice**  |
|  | Albany House, 14 Shute End Wokingham, Berks RG40 1BJ0118 974 0222 |

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| **DATA PROTECTION ACT 1998 – HOW WE USE YOUR PERSONAL INFORMATION** |

We collect data about you and your family during our initial and other meetings with you. We will also collect data about you and your family from other people. We collect the data through note-taking and filling in of fact-finds and questionnaires about you and your family’s circumstances.

We may make checks with credit rating agencies to authenticate and verify your identity and credit status. We also make checks with organisations with whom you have policies of insurance and investments and with your mortgage provider. These checks are to help us with our legal obligations and to ensure that we provide you with advice that suits your circumstances. The scope and extent of the gathering of information from third parties depends on what type of service you are taking from us.

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| **HOW IS YOUR INFORMATION USED?** |

Primarily, we use your data and data about your family’s circumstances to provide financial advice to you and complete transactions on your behalf. We analyse and assess your data to maintain and develop our relationship with you.

Depending on the instructions we receive from you, we may pass your data to other professional advisers to enable us to provide advice most suited to your circumstances. Usually, this would be referrals to accountants, solicitors, tax advisers and sometimes to specialist advisers in the financial and insurance industry where you may benefit from the expertise of such third parties. We, and any third party specialist advisers to whom we introduce you, will pass your data to organisations when you agree to purchase or amend policies and products.

We will retain your data in accordance with law and regulation. For instance, if you are given specialist pension advice, the data will be retained indefinitely. If you want details of the statutory retention periods for the differing product types and classes of data please contact us.

We may be required to share your data with our regulator and other third parties including our auditors or insurers.

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| **YOUR RIGHT TO A COPY OF YOUR PERSONAL DATA** |  |

Under the Data Protection Act you have a right, on payment of a fee, currently £10, to obtain a copy of the personal information that we hold about you. If you believe that any information held is incorrect or incomplete, you should contact our Data Protection Officer at our usual address. Any information that is found to be incorrect or incomplete will be amended promptly.

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| **OUR PRODUCTS AND SERVICES** |

We provide advice on a wide portfolio of financial products. We believe these are some of the best and most appropriate in the marketplace. We would like to be able to contact you so that we can advise you of new products that might be suited to you. We also may advise you of any developments that might make it appropriate for us, or for third parties, to give you pro-active advice about the investments, insurance and other financial products of which we are aware. We stress that your information would only be used in this way to help us to provide a pro-active service to you.

There may be times when we feel that a service or product may be of interest to you. In order to make you aware of these services or products, we, insurers or third parties may wish to contact you so that you can make informed choices about your finances. Please indicate your preferences using the boxes below.

|  |
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| Please indicate if we can contact you. Please tick either one or both boxes so that we can advise you of products and services from time to time. □ Yes, please give me details about products or services in which you think I may be interested. □ Yes, I am happy for you to pass my details to carefully selected third parties so they can contact me about their products and services. |