

# Application Form

For Adviser use only

Agent Number

Application Ref. Number

Intermediary Ref.

# Guidance Notes

## ONLINE APPLICATIONS

If you are using this form as a data capture form and applying online through your adviser, the information you supply on this form will then be transferred electronically to Scottish Widows by your adviser.

Your adviser will then return the signed Application Form to us with a completed Money Laundering Certificate (to be supplied by your adviser where applicable).

**NB: Please note that the whole form must be signed and returned to Scottish Widows within 28 days of applying online or your plan will be cancelled.**

## PAPER APPLICATIONS

If you are using this form as a paper application, please ensure you sign the Customer Signature Form and the Direct Debit Instruction. You or your adviser should then return the whole form to us along with a completed Money Laundering Certificate (where applicable).

## APPLICATION SUMMARY

If you are sent a summary of the information used to complete your Application, it is important that you check this thoroughly and inform us of any errors.

### **IMPORTANT – READ THIS BEFORE YOU SIGN**

**You must tell us everything that may affect your application. If you have any doubt whether facts are relevant, please tell us about them.**

**Please be aware that we may not cover you in the event of a claim if:**

- **You have not given us all the material facts; or**
- **You don't let us know about any change in the material facts before the plan starts.**

### **MATERIAL FACTS**

When you apply for insurance of any kind, it is most important to give the insurance company all the “material facts”, otherwise you could find that your plan is invalid when it comes to making a claim and no benefit will be payable.

A material fact is any information that is likely to affect our decision to accept your application or the level of payments to be made. You are legally obliged to disclose this kind of information to us, even if the application form has not asked specific questions about it. So if you are not sure whether a fact is material or not, you must include it on your application form.

If we ask you to have a medical examination in connection with this application, the answers you give to the doctor count as material facts. If we ask for your permission to contact other insurance companies about your medical history, again the facts we collect in this way are material facts.

Before you sign the Customer Signature Form, please make certain that all the information you have given in connection with your application is complete and true.

Please note that failure to give correct details may result in non-payment of a claim.

# 1. Personal details

	First or Only Life Assured	Second Life Assured
Surname	<input type="text"/>	<input type="text"/>
First Name(s)	<input type="text"/>	<input type="text"/>
Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="text"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="text"/>
Marital Status	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>
Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Nationality	<input type="text"/>	<input type="text"/>
In the last 12 months have you used any tobacco products?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Tobacco products include cigarettes, cigars, pipes or nicotine replacements.

**As part of random sampling, non-smokers may be subject to a test to confirm non-smoking status (e.g. saliva sample).**

NB: We need proof of age and proof of change of name if applicable (e.g. a marriage certificate) before paying a claim. Please send the originals of these documents to us. We will return them to you.

# 2. Plan type

a) Please tell us which type of plan you are applying for, the level of protection (sum assured) you need or how much you wish to pay, and we will work out how much cover this will provide.

	Sum Assured £	Payment £	Term (in years)	Payment Cover (✓) (optional)	
				1st life	2nd life
Level Term Assurance	£	£	yrs		
Level Term Assurance with Critical Illness Cover	£	£	yrs		
Level Term Assurance (Critical Illness Cover only)	£	£	yrs		
Mortgage and Business Cover	£	£	yrs		
Mortgage and Business Cover with Critical Illness Cover	£	£	yrs		
Mortgage and Business Cover (Critical Illness Cover only)	£	£	yrs		

b) Please indicate on what basis the plan is to be set up. Single Life  Joint Life\*

\* If the plan is to be joint life, the benefits should be payable on first death or illness, as relevant.

c) Payment Frequency Monthly  Yearly

(Please note that the yearly payment option is not available for Mortgage and Business Cover.)

NB: Please do not send cheques to Scottish Widows for monthly or yearly payments. Both monthly and yearly payments will be collected by direct debit. In the case of yearly payments, we will issue a renewal notice.



Please note that failure to give correct details may result in non-payment of a claim.

## 6. Doctor's name and address

	First or Only Life Assured	Second Life Assured
<b>Current Doctor</b>		
Name	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Telephone Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

### Previous Doctor

Have you changed your doctor in the last 12 months?      Yes  No       Yes  No

If 'Yes', please state previous doctor's name and address.

Name	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Telephone Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

## 7. Existing cover

	First or Only Life Assured	Second Life Assured
a) Have you been accepted for any Scottish Widows plan in the last 2 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', please give plan number(s).	<input type="text"/>	<input type="text"/>
b) Do you have any other life insurance or critical illness cover, or is any application pending? (Please include any plans/applications with or sold through the Lloyds TSB Group).	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) How much critical illness cover do you have?	<input type="text"/>	<input type="text"/>
d) Has any application for life insurance, critical illness cover or health insurance ever been declined, deferred or accepted on non-standard terms?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', please give full details, including company.	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

Please note that failure to give correct details may result in non-payment of a claim.

## 7. Existing cover (continued)

**First or Only Life Assured**

**Second Life Assured**

e) Have you ever withdrawn an application before the company advised you of its decision?

Yes  No

Yes  No

If 'Yes', please give full details, including company.


f) Is this application to replace an existing Scottish Widows plan? NB: Not applicable for applications submitted online.

Yes  No

Yes  No

If 'Yes', please give plan number if known.



## 8. Habits

**First or Only Life Assured**

**Second Life Assured**

a) If you smoke cigarettes, please state your daily consumption.

 cigarettes each day

 cigarettes each day

b) Do you drink alcohol?

Yes  No

Yes  No

If you drink alcohol, please state how many units of alcohol you drink each week (1 unit = 1 glass of wine, 1 measure of spirits or half a pint of beer).

 units each week

 units each week

c) What is your height (without shoes)?

 feet  inches

 feet  inches

or

 metres  centimetres

 metres  centimetres

d) What is your weight (in normal indoor clothing)?

 stones  pounds

 stones  pounds

or

 kilos

 kilos

Please note that failure to give correct details may result in non-payment of a claim.

## 9. Occupation

**First or Only Life Assured**

**Second Life Assured**

a) What is your main occupation? Please give full details.


b) Does your occupation involve using explosives, handling firearms or weapons (including for self-defence)?

Yes  No  Yes  No

c) Does your work involve any manual or physical work?

Yes  No  Yes  No

If 'Yes', please describe in full, including any work at heights (in feet or metres) and/or work with machinery or tools (please indicate percentage of day spent in each activity).


## 10. Health details

Please note that further questions may be asked when applying online depending on the answers you give. If required, your adviser will complete these with you. A copy of these additional questions and answers will be included in the Application Summary we will send to you.

The additional questions and answers shall form part of this application, and the same terms, conditions, declarations and consents shall apply.

**First or Only Life Assured**

**Second Life Assured**

a) Have you in the last 5 years consulted a doctor or other medical professional, or had, or been advised to have any operation, x-ray, check-up or any other investigation or test or are you intending to do so?

You can ignore consultations for the following: blisters, common cold, contraception, ear wax or syringing, influenza, in-growing toenails, routine and holiday vaccinations, sinus trouble, tonsillitis, wisdom teeth.

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


**Please note that failure to give correct details may result in non-payment of a claim.**

**First or Only Life Assured**

**Second Life Assured**

b) Are you currently, or have you in the last 5 years been prescribed medication, therapy, counselling or any other form of treatment?

You can ignore the following: oral contraception, routine and holiday vaccinations.

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


c) Have you ever suffered from any disorder of the heart or circulation, high blood pressure, stroke or diabetes?

You should include any of the conditions mentioned in the question and any of the following: aneurysm, angina, blockage or narrowing of an artery, cardio-myopathy, congenital heart abnormalities, disease of an artery or vein, electrocardiogram (ECG) abnormalities, inflammation of an artery or vein, heart rhythm disorders, low blood pressure, raised cholesterol, transient ischaemic attacks (TIA).

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


d) Have you ever suffered from cancer, tumours, growths, lumps or cysts?

You can ignore the following if no hospital investigation was required and you are not waiting to see your G.P: blisters, verrucas.

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


e) Have you ever suffered from heart disease, stroke or brain haemorrhage, diabetes, kidney disease, multiple sclerosis, visual disturbance, pins and needles or dizziness?

You should include any of the conditions mentioned in the question and any of the following: aneurysm, angina, blockage or narrowing of an artery, cardio-myopathy, congenital heart abnormalities, disease of an artery or vein, electrocardiogram (ECG) abnormalities, inflammation of an artery or vein, heart rhythm disorders, low blood pressure, optic neuritis, raised cholesterol, retrobulbar neuritis, transient ischaemic attacks (TIA), transverse myelitis.

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


f) Have you ever suffered from any disorder of the digestive system, bowel, stomach, liver, kidney, bladder or urinary tract?

You can ignore the following if no hospital investigation was required and you are not waiting to see your G.P: sickness/vomiting, stomach bug/upset.

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


**Please note that failure to give correct details may result in non-payment of a claim.**

g) Have you ever suffered from any disorder of the nervous system, paralysis, epilepsy or fits, facial pain, numbness or tingling?

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


h) Have you ever suffered from asthma, bronchitis, emphysema or any other disorder of the respiratory system?

You can ignore the following: common cold, influenza, sinus trouble.

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


i) Have you ever suffered from anxiety, depression, nervous breakdown, stress, eating disorder, chronic fatigue, tiredness or any other mental illness?

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


j) Have you ever suffered from rheumatoid arthritis, blood diseases, thyroid disorders or gout?

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


k) Are you currently suffering from, or have you in the past suffered from, any physical complaint or disability, illness or injury not mentioned above?

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


l) Have you ever had more than 7 days off work consecutively in the last 2 years?

You can ignore if this was not as the result of a medical condition.

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


m) Have you ever had more than 4 weeks off work consecutively?

You can ignore if this was not as the result of a medical condition.

Yes  No  Yes  No

If 'Yes', please give the full name and details of the condition(s).


Please note that failure to give correct details may result in non-payment of a claim.

**First or Only Life Assured**

**Second Life Assured**

n) Have you ever suffered from back, neck, joint or disabling muscle pain, arthritis, sciatica, skin disorders, defective sight or hearing?

You can ignore the following: dry eyes, ear wax or syringing, styes.

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


o) Have you tested positive for HIV/AIDS or Hepatitis B or C, or have you been tested/treated for other sexually transmitted diseases, or are you awaiting the result of such a test?

You can ignore Hepatitis tests in connection with your occupation, unless the result was positive.

Yes  No

Yes  No

If 'Yes', please give the full name and details of the condition(s).


# 11. Family History

**First or Only Life Assured**

**Second Life Assured**

a) Have any of your family – father, mother, brother(s), sister(s) – died or suffered from diabetes, heart trouble, high blood pressure, kidney disease, stroke, cancer or hereditary disorder?

Yes  No

Yes  No

If 'Yes', which relation(s) suffered from the condition.


b) What condition(s) did this relation suffer from?


Choose from:

- Alzheimers Disease
- Cancer – breast
- Cancer – colo-rectal (i.e. colon, bowel, rectum)
- Cancer – ovarian
- Cancer – other sites (i.e not breast, colo-rectal or ovarian)
- Cardiomyopathy
- Diabetes
- Familial Adenomatous Polyposis of the Colon
- Heart Disease
- High Blood Pressure
- Huntington's Chorea
- Kidney Disease (other)
- Motor Neurone Disease
- Multiple Sclerosis
- Parkinson's Disease
- Polycystic Kidney Disease
- Stroke
- Unknown/natural causes
- None of the above

c) At what age(s) were they first diagnosed?

--	--

Please note that failure to give correct details may result in non-payment of a claim.

## 12. Residency

**First or Only Life Assured**

**Second Life Assured**

- a) Were you born outside the UK?      **Yes**       **No**       **Yes**       **No**
- If **'Yes'**, in which country were you born?
- How long have you been resident in the UK?
- b) What is your country of residence?
- c) Apart from holidays, do you intend to travel, work or reside outside the UK, or have you done so within the last 12 months?      **Yes**       **No**       **Yes**       **No**
- If **'Yes'**, which country is involved?

## 13. Hobbies

**First or Only Life Assured**

**Second Life Assured**

Have you any intention of participating in any hazardous activities, including, but not restricted to: flying, climbing, diving, or motor sports?

Flying includes aviation as part of an occupation or pastime, but not as a fare paying passenger. Motor sport includes any type of racing including rallying, sprints, hill trials, time trials and pursuits where a motor car or motor cycle is used.

- Yes**       **No**       **Yes**       **No**
- If **'Yes'**, which activities do you take part in?
-

**Please now do the following:**

- Read the Important Notes (and keep for information)
- Sign the Customer Signature Form (at the back of this application form)
- Complete the Direct Debit Instruction

# Important Notes

**Please ensure you read these notes carefully, then keep them for information.**

## **Data Protection Act**

The information you provide on the application form will be used by Scottish Widows to set up and administer your plan. We may also use it for market research, statistical purposes and the prevention and detection of fraud. If necessary a copy of the application form and any other supporting information may be given to a reinsurance company who will share the risk with us. We will keep the information you have supplied confidential and will not share it with others without your agreement, except where the law permits, when it may be disclosed to law enforcement agencies, Ombudsman and Regulators. Your information may be shared with financial advisers or people acting on your behalf. It may also be shared amongst Scottish Widows and Lloyds TSB Group companies to: provide the service you applied for, to update our records and to identify other products and services which may interest you. Other Lloyds TSB Group companies will not make marketing approaches to you unless you already have a relationship with them. Under the terms of the Data Protection Act you are entitled to request a copy of information we hold relating to you. A small charge will be payable.

Any information which you have provided relating to your health or lifestyle is required for underwriting purposes and is defined as "sensitive data" by the Data Protection Act. This information will be held securely with access limited to those who need to see it. In cases where, on health grounds, individuals are declined life assurance or are only offered life assurance at an increased premium, this information may be shared via a central register with other insurance companies as a safeguard against non-disclosure or fraudulent claims. We may record and monitor telephone calls with you in case we need to check we have carried out your instructions correctly and to help improve our quality of service.

## **Money Laundering Regulations**

Under current regulations we are required to verify the identity of our customers. In order to meet this requirement and for the prevention and detection of fraud, we will access information from a credit reference agency\* to confirm your identity. They will authenticate your name and address, which involves checking the details you supply against those held on any databases that the company carrying out the checks on our behalf (or any similar company) has access to. This includes information from the Electoral Register. We will use scoring methods to authenticate your identity. Our search will not be used by lenders or insurers when assessing lending or insurance risks. We may also pass information to financial and other organisations involved in money laundering and fraud prevention to protect ourselves and our customers from theft and fraud. If you give us false or inaccurate information and we suspect fraud, we will record this and share this information with other organisations.

If you provide us with information about another person, you confirm that they have appointed you to act for them to consent to the processing of their personal data. This means that you have informed them of our identity and the purpose for which their personal data will be processed, namely to verify their name and address. Where Scottish Widows receives notification affecting the legal ownership of the plan, e.g. Power of Attorney, the same process as set out above will apply.

Please note that if we cannot confirm your name and address by using a credit reference agency, we may contact you to ask you to supply certain documents to verify your name and address. If you ask, we will tell you which credit reference agency we have used so you can get a copy of your details from them.

**\* Please note we only use this agency to verify identity to fulfil anti-money laundering regulations and not to check credit worthiness.**

## **Contracts (Rights of Third Parties) Act 1999**

Please note that when a plan is taken out, the contract is between the applicant(s) and Scottish Widows. The terms of the Contracts (Rights of Third Parties) Act 1999 and any other legal third party rights are specifically excluded. This means that only the parties to the contract (or their legal successor(s)) will have contractual rights.

## **Genetic Testing**

In accordance with the Association of British Insurers' policy on genetics and insurance, you do not need to tell us about any genetic test result you have had if this application for insurance, taken together with any other insurance policies you already have for this type of insurance, totals: £500,000 or less for life insurance; £300,000 or less for critical illness. Above these limits, you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government's Genetics and Insurance Committee (GAIC) has approved them for insurers to use. If you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at [www.abi.org.uk/consumer2/disclosure.htm](http://www.abi.org.uk/consumer2/disclosure.htm). However, you must tell us if you either have a family history of, are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. If you wish to disclose to us a negative genetic test result, which shows us that you have not inherited a genetic disorder, we will take this into consideration when assessing your application, (providing your clinical geneticist confirms that this test result indicates a reduced risk of developing the inherited disease).

## **Medical Information**

You must tell us everything that may affect your application. If you have any doubt whether facts are relevant, please tell us about them. If you do not give us this information, we may not cover you in the event of a claim. Please note that we reserve the right to request a medical examination within 30 days after the commencement date of your plan. This forms part of our quality control procedures and individual cases accepted without medical evidence are selected at random. We may carry out an examination which includes cotinine testing for tobacco products. In the event that information is not forthcoming or if the examination highlights a material fact which you have knowingly failed to disclose, we reserve the right to amend the terms or cancel your plan. You must notify us of any changes which occur before the plan is issued.

**Please note, should you die before we receive your signed Customer Signature Form, we will approach your estate for consent to access your medical records. If consent is not granted then Scottish Widows may not pay out on your plan.**



# Customer Signature Form (Page 1 of 2)

Please note that the General Practitioner's Report Declaration Consent should be read before you sign the Customer Signature Form

## General Practitioner's Report Declaration and Consent

### Important Notes

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

If we ask you to come for a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered.

Or, we may need to send them at a later stage for purposes relating to managing the policy or a claim. You can get details of general reinsurance principles and details of any company we use to assess your application from our head office.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

You are entitled to ask for a copy of our standard terms and conditions (policy and provisions) and a copy of your application form at any time.

#### **The Access to Medical Reports Act 1988, The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and The Access to Health Records and Reports (Isle of Man) Act 1993**

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 under the appropriate Act detailed above. Your rights under the appropriate Act are as follows.

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.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report, or any part of it, if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following.

- Your current health.
  - Any care, medication or treatment you are currently receiving.
  - The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
  - Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
    - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
    - musculoskeletal disease or injury, for example arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
    - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
    - suicidal thoughts or attempts at suicide; or
    - conditions related to drug or alcohol misuse or smoking or chewing tobacco products.
  - Details of any biopsies, blood tests, electrocardiograms (heart tests), height and weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
  - Any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.
- We have asked your doctor not to reveal information about:
  - negative tests for HIV, Hepatitis B or C;
  - any sexually-transmitted diseases unless there could be long-term effects on your health; or
  - predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.
- The information you and your doctor provide about your health may result in us:
  - refusing to provide insurance;
  - increasing premiums above standard rates;
  - setting premiums at standard rates; or
  - applying additional exclusions.

If you have any questions about your rights under the appropriate Act or questions relating to the process of getting, assessing or storing medical information, please write to:

**Principal Medical Officer**  
**Scottish Widows plc**  
**15 Dalkeith Road**  
**Edinburgh**  
**EH16 5BU**



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



Originator's ID Number: 837052

Please write and/or check your Bank/Building Society details in the boxes provided below.  
A Direct Debit Instruction will be created to take payments from your account.

Account Name

Account Number

Sort Code

 -  - 

Branch Name

Please pay Scottish Widows plc 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 Scottish Widows plc and, if so, details will be passed electronically to the Bank/Building Society detailed above.

Signature(s)

Date

   

Date

   

NB: No signature is required for applications submitted online.

## 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 Scottish Widows will notify you 14 days in advance of your account being debited or as otherwise agreed.
- If an error is made by Scottish Widows 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.

1. This Direct Debit is solely for the purpose of this plan.
2. Banks and Building Societies may not accept Direct Debit Instructions for some types of account.
3. For joint or individual accounts, you must be the only person required to authorise debits from the account.
4. The Bank/Building Society Account holder and Protection applicant must be the same person (if a joint account is to be used the Protection applicant must be one of those named as an account holder).
5. If your plan starts less than 14 days before the chosen payment date on your application, the first two monthly payments will be collected from your initial payment. Subsequent payments will then be the agreed monthly amount.



Scottish Widows plc. Registered in Scotland No. 199549. Registered Office in the United Kingdom at 69 Morrison Street, Edinburgh, EH3 8YF. Tel: 0131 655 6000.

Scottish Widows plc is a member of the Scottish Widows and Lloyds TSB Marketing Group, members of which carry on the business and services associated with life assurance, pensions and investments. Scottish Widows plc acts as the processing and paying agent for Scottish Widows Annuities Limited.

Scottish Widows plc is authorised and regulated by the Financial Services Authority.