Irish Life

Standalone Life Options Life Insurance

Application form

Please read the questions carefully before answering and use CAPITAL LETTERS throughout.

Financial adviser's details

Financial Adviser's name | Financial Adviser's code | Email address

Financial Adviser's phone number | Branch

A. PERSONAL DETAILS - Everyone must fill in this section

First person to be covered

Mr ○ Mrs ○ Ms ○ Other ○

Gender Male ○ Female ○

First name

Last name

Date of birth / /

Smoker Yes ○ No ○

Relationship status Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Registered Civil Partner ○

Home address - (We cannot accept a 'care of' address)

Country of birth

Country of residence

Previous surname (if any)

Precise occupation

Current level of earnings € each year

Home phone*

Work phone*

Mobile phone*

Email address

Second person to be covered

Mr ○ Mrs ○ Ms ○ Other ○

Gender Male ○ Female ○

First name

Last name

Date of birth / /

Smoker Yes ○ No ○

Relationship status Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Registered Civil Partner ○

Home address (if different) (We cannot accept a 'care of' address)

Country of birth

Country of residence

Previous surname (if any)

Precise occupation

Current level of earnings € each year

Home phone*

Work phone*

Mobile phone*

Email address

*Please note: If provided, we will be able to phone you to seek any additional information we may need.

Existing cover with Irish Life or Irish Progressive

If you have existing cover with Irish Life or Irish Progressive which you wish to cancel when your new plan is issued please complete this section.

Plan number(s)

Would you like to cancel the above plan number(s) when your new cover has been issued? Yes ○ No ○

Is this plan currently assigned to a lender or used to protect your mortgage ? Yes ○ No ○
(if yes please read the following important note)

Important note: You must arrange with your lender to release the assignment of your plan(s). When we receive the release of assignment we will cancel your existing cover (we will not be in a position to refund any further payments collected in the mean time).

Is this plan being set up under a conversion option from an existing Irish Life or Progressive Life plan? Yes ◯ No ◯

Please provide plan number or group scheme name/number under which the conversion is being exercised

Is the plan from which the conversion option is being exercised assigned or held in trust? Yes ◯ No ◯

If this plan is being set up under a conversion option, you do not need to complete Section C

Will the owner of this plan (proposer) be different from the life covered? Yes ◯ No ◯

If the plan owner (proposer) is not the life to be covered please complete the following:

Plan owner name | Date of birth / /

If company - company name

Address of plan owner

Reason for cover (if relationship not husband & wife)

Is the plan to be written in trust? Yes ◯ No ◯
If so, please complete the appropriate trust form.

Assuming the plan owner is not different from the persons covered, and the plan is not to be assigned or written in trust, please confirm who can authorise transactions. [1]

All plan owners only ◯ Any one plan owner ◯ First person covered ◯ Second person covered ◯

[1] This does not apply if you are reducing your benefits, or cancelling/cashing in your plan/claiming benefits.

Is this application in connection with a mortgage? Yes ◯ No ◯

If Yes, is the cover amount required less than or equal to the mortgage amount? Yes ◯ No ◯

Is your intention to assign this plan to a lender when issued? Yes ◯ No ◯

B. LIFE OPTIONS LIFE INSURANCE PLAN (UNIT LINKED)

Term of Cover

Standard (to age 65) ◯ Whole of Life ◯ 20 yrs ◯ other, please give details yrs

	First person	Second person
Amount of Life Cover you want (if any)	€	€
Amount of Specified Illness Cover you want (if any)	€	€
If you have chosen Specified Illness Cover, which type do you want?	Accelerated [2] ◯	Accelerated ◯
	Independent [3] ◯	Independent ◯

[2] Accelerated Specified Illness Cover means we reduce your Life Cover by the amount of the specified illness claim and it cannot be greater than the Life Cover.
[3] Independent Specified Illness Cover means that if you make a specified illness claim, it will not affect any Life Cover. If you choose Life Cover and Specified Illness Cover and do not choose a basis, we will assume the Specified Illness Cover is independent.

Warning: The current premium may increase after year 10.

C. MEDICAL AND OTHER INFORMATION - IF THIS PLAN IS BEING SET UP UNDER A CONVERSION OPTION, YOU DO NOT NEED TO COMPLETE THIS SECTION - PLEASE SKIP TO SECTION D

Important - Telling Irish Life about material facts

Please remember that you must tell us everything relevant when answering all of the questions on the application form. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. This includes disclosing tobacco consumption. If failure to reveal all facts occurs there will be no cover under the plan and we will not refund the payments.

In these circumstances we will not pay a claim. A material fact (relevant information) includes anything that a reputable insurer would treat as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the section 'Other medical evidence'. We may also contact you by telephone if we need to ask you for further information on your answers to the health questions or as part of any subsequent claim investigation. If we phone you these calls will be recorded.

We will rely on what you tell us and you must not assume that we will automatically clarify or confirm any information you provide. You can provide any highly confidential information directly to Irish Life's Chief Medical Officer in a sealed envelope with your name, date of birth and application number (if applicable) and give this to your financial adviser. In these circumstances you must refer to this information when answering your health questions.

You should not tell us about any genetic test (that is, any analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. You must however, tell us if you are having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

If your health changes between the date you apply for cover and the date your application is accepted, you must let us know immediately as failure to do this may result in a claim being refused.

If for whatever reason there is more than a 6 month delay between the time your application is accepted and the date your plan starts (is issued), and your health has changed then you must also let us know immediately.

MEDICAL DETAILS - INSTRUCTIONS

After you have read the note about material facts, please fill in these questions by ticking the boxes marked 'yes' or 'no' (whichever is appropriate). If you answer 'yes' to any questions, please give full details. If you need more space, please fill in the 'other medical evidence' section. Please fill in the Fast Track underwriting Medical Questionnaire, if this is appropriate.

	First person to be covered	Second person to be covered
1. Please give the name and address of your doctor.		
If you have changed doctor in the last year, please give the name and address of your previous doctor as well.		
IMPORTANT **2. Please give your height and weight**	feet inches stones lbs cms kilos	feet inches stones lbs cms kilos
3(a). Have you smoked tobacco of any kind in the past 12 months or do you intend to smoke in the future? (This includes even occasional tobacco comsumption)	Yes ◯ No ◯	Yes ◯ No ◯
3(b). Do you consume any other form of tobacco. If YES, please supply details	Yes ◯ No ◯	Yes ◯ No ◯
If you smoked tobacco of any kind in the last 12 months or you intend to smoke in the future, please fill in the following [10]		
Cigarette / Cigar / Pipe Smoker	☐ per day ☐ Grams per day	☐ per day ☐ Grams per day

[10] Please include each type of tobacco you consume on a daily basis. A pipe smoker should indicate the number of grams per day. It is our practice to carry out occasional testing to confirm non smoker status.

Note – Not revealing tobacco consumption on this application form could result in a potential claim being refused

	First person to be covered	Second person to be covered
4. Please enter your **weekly** consumption of alcohol in units		
Or tick if you are a non drinker	◯	◯

Unit Guide: Pint Beer - 2.0 units, Bottle Beer - 1.5 units, Glass beer - 1.0 units, Measure spirits - 1.0 units, Bottle wine - 7.0 units, Glass wine - 1.0 units.

5. Have you ever suffered from or had treatment for heart disorder, stroke, rheumatic fever, high blood pressure or blood disorder?	Yes ◯ No ◯	Yes ◯ No ◯
6. Have you ever suffered from or had treatment for asthma, bronchitis or another lung disorder?	Yes ◯ No ◯	Yes ◯ No ◯

	First person to be covered	Second person to be covered
7. Have you ever suffered from or had treatment for multiple sclerosis, numbness, epilepsy, blackouts, paralysis or double vision?	Yes ◯ No ◯	Yes ◯ No ◯
8. Have you ever suffered from or had treatment for kidney or bladder disorder?	Yes ◯ No ◯	Yes ◯ No ◯
9. Have you ever suffered from or had treatment for diabetes or a stomach, liver or bowel disorder?	Yes ◯ No ◯	Yes ◯ No ◯
10. Have you ever suffered from or had treatment for cancer or any other growth or tumour?	Yes ◯ No ◯	Yes ◯ No ◯
11. Have you ever suffered from or had treatment for a mental or nervous disorder?	Yes ◯ No ◯	Yes ◯ No ◯
12. Have you ever suffered from or had treatment for slipped disc, back, arthritic or muscular disorder?	Yes ◯ No ◯	Yes ◯ No ◯
13. Have you ever suffered from or had treatment for disorder of the eyes or ears (other than wearing prescribed glasses or contact lenses)?	Yes ◯ No ◯	Yes ◯ No ◯
14. Have you ever suffered from or had treatment for any other illness, injury or condition for which you have had medical advice in the last five years?	Yes ◯ No ◯	Yes ◯ No ◯
15. Have you had a surgical operation in the last five years?	Yes ◯ No ◯	Yes ◯ No ◯
16. Have you in the last five years had or been advised to have any special investigations, blood or laboratory tests?	Yes ◯ No ◯	Yes ◯ No ◯
17. Are you currently taking prescribed drugs, medicines, tablets or other treatment?	Yes ◯ No ◯	Yes ◯ No ◯
18. Are you currently unwell or receiving medical treatment of any kind, which you have not mentioned in the answers given above?	Yes ◯ No ◯	Yes ◯ No ◯
19. Have you ever taken drugs for other than medical purposes(including 'recreational' drugs) or have you suffered from, had treatment for or been given medical advice for excess alcohol consumption?	Yes ◯ No ◯	Yes ◯ No ◯
20. Have you ever tested positively for HIV or AIDS, Hepatitis B or Hepatitis C or are you waiting for the result of this kind of test?	Yes ◯ No ◯	Yes ◯ No ◯
If YES, please supply details		
21. Have you any intention or prospect of taking part in any kind of dangerous activity as a result of your hobbies or pastimes? If YES, please supply full details.	Yes ◯ No ◯	Yes ◯ No ◯
22. Have you any future intention of living or travelling outside of the EU, North America, Australia or New Zealand, other than for holidays or have you lived outside these areas in the past for longer than 12 months?	Yes ◯ No ◯	Yes ◯ No ◯
If YES, please supply names of countries, reasons for visits and durations of stays.		
23. Have you ever applied to Irish Life or any other insurer and been refused, postponed or accepted on special terms for life cover, disability or illness cover?	Yes ◯ No ◯	Yes ◯ No ◯
24. Have your parents or any of your brothers or sisters suffered fromor died from heart disease including cardiomyopathy*, stroke, kidney disease, cancer (bowel, breast, ovarian or other), motor neurone disease, multiple sclerosis, Huntington's disease, polycystic kidneys, polyposis of the colon or other hereditary disorder before age 60? Note: If you are adopted please answer "no" to this question.	Yes ◯ No ◯	Yes ◯ No ◯

* Cardiomyopathy is a disease affecting the heart muscle. Huntington's disease is a hereditary disorder which affects the central nervous system. Polycystic kidneys is a disease where cysts develop in the kidneys. Polyposis of the colon is a disease where growths occur in the bowel.

		Condition suffered	Age when it started
First person to be covered:	Father		
	Mother		
	Brothers		
	Sisters		
Second person to be covered:	Father		
	Mother		
	Brothers		
	Sisters		

N.B If a relative had cancer, please state which part of the body affected.

OTHER MEDICAL EVIDENCE

31. If appropriate, you should also fill in the supplementary Fast Track Underwriting Questionnaire.

First person to be covered

Question numbers	Details

Second person to be covered

Question numbers	Details

32. Is there a Fast Track Underwriting Questionnaire or any other questionnaires accompanying the application form?

	Yes ◯	No ◯	Yes ◯	No ◯
If YES, please indicate which type of Questionnaire				

D. DATA CONSENTS

I consent to Irish Life Assurance plc (Irish Life)

Data Protection Consents

A Processing and holding (on computer or otherwise) all information disclosed by me, or on my behalf or in conjunction with any applications made by me (or subsequently), including sensitive personal data (being medical records) and/or financial details for the purposes of underwriting, issuing and administering all aspects of the plan.

B Disclosing my personal data for the above purposes and to persons necessary in connection with the above purposes, to regulatory authorities or as required by law, to reinsurers, to health professionals, to any persons with whom Irish Life has a contract as a service provider, to other insurance companies, to other companies within Irish Life Group Limited and to any person to whom the plan may be assigned.

E. DECLARATION UNDER REGULATION 6(3) OF THE LIFE ASSURANCE (PROVISION OF INFORMATION) REGULATIONS 2001.[11]

[11]**All customers must sign and date these declarations.**

Warning
If you propose to take out this plan to totally or partially replace an existing plan, please take special care to make sure that this plan meets your needs. In particular, please make sure that you are aware of the financial consequences of replacing your existing plan. If you are in doubt about this, please contact your insurer or insurance intermediary.

Ref: Plan number

Please fill in this section by ticking the appropriate box: Yes, the plan is a replacement of an Irish Life (or Progressive Life) plan. ◯

Yes, the plan is a replacement of a plan from another Life company. ◯ No, the plan is not a replacement plan. ◯

If applying for more than one plan, please state the name of the plan(s), and which replace an existing plan (if any).

Plan owner (proposer) name and address

Declaration of the intermediary
I confirm that in line with regulation 6(1) of the Life Assurance (Provision of Information) Regulations 2001,
has been provided with the information set out in schedule 1 to those regulations and that I have advised the client as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement.

Signature of seller Date / /

for

name of intermediary or insurer

Declaration of client
I confirm that I have received, in writing, the information specified in the above declaration.

Note: If the plan owner (proposer) is different from the life assured, this declaration must be signed by the plan owner.

Signature Date / /

Signature of second person to be covered (where applicable) Date / /

F. DECLARATION

I understand that this declaration, together with the other declarations and consents in my application form (a copy of which will be sent to me shortly and which is based on the information given by me to Irish Life) is my application for cover under Irish Life's normal conditions.

I understand and agree that my contract with Irish Life Assurance plc (Irish Life) will be based on the declarations and consents in this application form completed (online or otherwise), any supplementary questions answered, any statements made to Irish Life's underwriting team in response to any phone calls received and any information I give to a medical examiner acting for Irish Life and all terms and conditions furnished to me by Irish Life.

I have read and understand the important information concerning my obligation to tell Irish Life about all material facts in connection with the application (Important - Telling Irish Life about material facts) in this booklet and I understand that if I do not tell Irish Life all material facts, this contract could be void. If this happens, there will be no cover under the plan and Irish Life will not refund my payments. In these circumstances, Irish Life will not pay a claim.

I declare that all statements recorded in answer to the questions in my application form including those about tobacco consumption (together with any statements written down by me or for me) are true and complete. I understand that I will receive a copy of the application form questions and my answers for my own records.

I understand that I must tell Irish Life in writing about any changes in my health or circumstances between the date I applied for cover and the date my application is accepted. I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment.

I consent to Irish Life obtaining information from or sharing information with
- any doctor who at any time has attended me concerning anything which affects my physical or mental health,
- any health professional for the purpose of processing my application or
- any insurance company where I may have applied, or may make a claim.

I authorise Irish Life to access and receive this information. I agree that this authority will stay in force after my death. I agree that this information (including any medical data) can be held for six years.

PLEASE TAKE TIME TO REVIEW YOUR ANSWERS TO THE QUESTIONS.

Signature of first person to be covered Date / /

Signature of second person to be covered (if any)

Signature of proposer(s) (if different from the people to be covered)

Where the signatory is acting in a representative capacity, please give details, eg John Smith (Director) for and on behalf of ABC Company Ltd.
You can ask us for a copy of your filled in application form.

G. PAYMENT DETAILS

Proposed payment amount [12] €

[12] Irish Life will validate the payment amount for this contract based on personal and plan details and if there is a difference, we will inform you before the plan is issued.

Frequency of direct debit every month ◯ every 3 months ◯ every 6 months ◯ every year ◯

What date each month do you want your direct debit taken (1st to 28th of month)? of each month

Do you want your cover to start immediately, if accepted? Yes ◯ No ◯

Note: If no we will write to you or your advisor to seek confirmation of the start date.

Irish Life

H. SEPA Direct Debit Mandate

Please complete all the fields below marked * and return this mandate to the Creditor

UMR

Creditor Identifier IE30ZZZ303587

Name and address of the payer:

* Debtor Name

Debtor Address

* Debtor Bank Identifier Code (BIC)

* IBAN

(Account Number)

Type of payment Recurrent ✔ or One Off Payment ◯

Creditor's name and address IRISH LIFE ASSURANCE PLC
LOWER ABBEY STREET
DUBLIN 1

By signing this mandate form, you authorise (A) Irish Life to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Irish Life. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Please sign and date

* Signature(s) ✗

✗

* Date of signing dd / mm / yyyy

For Irish Life Information purposes only

Plan Number (max 18 characters)

Person(s) on whose behalf payment is being made

Direct Debit collection date of the month (1st to 28th only)

Payment frequency Monthly ◯ Quarterly ◯ Half Yearly ◯ Yearly ◯

Irish Life

Direct Debit Mandate on reverse

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In the interest of customer service we will record and monitor calls.

ILA 7946 (REV 02-14)

Irish Life

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