Block Protection Application Form

Irish Life

Broker version

Application for insurance under Permanent TSB Group Mortgage Assurance plans. This is underwritten by Irish Life Assurance plc.
Please read the questions carefully before answering and use CAPITAL LETTERS throughout.

Financial adviser's details

Contact name | Seller code | Larc number | Email address

Contact phone number | Branch

A Personal Details - Everyone must fill in this section

First person to be covered	Second person to be covered
Mr ☐ Mrs ☐ Ms ☐ Other ☐	Mr ☐ Mrs ☐ Ms ☐ Other ☐
Gender Male ☐ Female ☐	Gender Male ☐ Female ☐
First name	First name
Last name	Last name
Date of birth / /	Date of birth / /
Smoker Yes ☐ No ☐ (This includes even occasional tobacco consumption)	Smoker Yes ☐ No ☐ (This includes even occasional tobacco consumption)
Marital status Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐	Marital status Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐
Home address - We cannot accept a 'care of' address	Home address (if different)
Country of birth	Country of birth
Previous surname (if any)	Previous surname (if any)
Precise occupation	Precise occupation
Current level of earnings € each year	Current level of earnings € each year
Home phone*	Home phone*
Work phone*	Work phone*
Mobile phone*	Mobile phone*
Email address	Email address
Mortgage Number	

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 ? (if yes please read the following important note) Yes ☐ No ☐

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).

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

B Life Options Plan (unit linked)

Term of Cover _____ 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 [1] ☐	Accelerated ☐
	Independent [2] ☐	Independent ☐

[1] 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.
[2] 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.

Do you want Contribution Cover ?[3] YES ☐ NO ☐

[3] We only provide Contribution Cover for the first person.

C Life Term Cover Plan (term assurance)

Term of cover [4, 5] _____ years

[4] The maximum term for cover is 40 years.
[5] The maximum expiry age for Specified Illness cover is age 75. However your life cover will continue to the end of your chosen term.

	First person	Second person
Amount of Life Cover you want	€	€
Amount of Specified Illness Cover you want	€	€
If you have chosen Specified Illness Cover, which type do you want?	Standalone ☐	Standalone ☐
	Accelerated ☐	Accelerated ☐
	Independent ☐	Independent ☐

Do you want Guaranteed Cover Again (convertible option)?[6] YES ☐ NO ☐

[6] You can only take out Guaranteed Cover Again if you are under 61. Guaranteed Cover Again is subject to a maximum of €1 million on Specified Illness Cover and €5 million on Life Cover. These limits are in respect of the total cover converted across all policies belonging to the life assured.

D Life Mortgage Cover (mortgage protection)

Term of cover [7, 8] _____ years

[7] The maximum term for cover is 40 years.
[8] The maximum expiry age if you have chosen Specified Illness cover is age 75.

Initial amount of life cover you want € _____

Initial amount of Accelerated Specified Illness Cover you want (if any)?[9] € _____

[9] The amount of Specified Illness Cover you choose can be different to the level of Life Cover but cannot exceed it.

E Payment details

Proposed payment amount [10] € _____

[10] 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

F Medical and other information

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. 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 to Irish Life chief medical officer in a sealed envelope with your name, date of birth and application number (if available) and give this to your financial adviser. In these circumstances you must refer to this information when answering your health questions.

You do not need to 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 time 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 Quick Underwriting (supplementary) 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.		
Please provide the name and address of your previous doctor if you have changed doctor in the last year.		
IMPORTANT **2. Please give your height and weight**	feet inches	feet inches
	stones lbs	stones lbs
or alternatively	cms kilos	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 consumption)	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 [11]		
Cigarette Smoker	☐ per day	☐ per day
Cigar Smoker	☐ per day	☐ per day
Pipe Smoker	☐ Grams per day	☐ Grams per day

[11] 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.

	First person to be covered	Second person to be covered
4. Please enter your **weekly** consumption of alcohol in units		
Please 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.

	First person to be covered	Second person to be covered
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 ☐
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 a slipped disc, back, arthritic or muscular disorder?	YES ☐ NO ☐	YES ☐ NO ☐
13. Have you ever suffered from or had treatment for a 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?	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?	YES ☐ NO ☐	YES ☐ NO ☐
If YES, please supply full details.		
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 ☐

	First person to be covered	Second person to be covered
24. Have your parents or any of your brothers or sisters suffered or 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.[12]	YES ☐ NO ☐	YES ☐ NO ☐

[12] 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
If living	Father		
	Mother		
	Brothers		
	Sisters		
If dead	Father		
	Mother		
	Brothers		
	Sisters		

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

Other medical evidence

25. 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

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

	First person to be covered	Second person to be covered
YES ☐ NO ☐	YES ☐ NO ☐	
If YES, please indicate which type of Questionnaire		

G Declaration under regulation 6(3) of the Life Assurance (Provision of Information) Regulations 2001.[13]

[13] 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.

Declaration of the intermediary

Customer name and address

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 set out in the declaration above.

Signature (1st person to be covered) Date / /

Signature (2nd person to be covered) Date / /

H Payment paying arrangements

I agree that all payments for this insurance cover will be paid to Permanent TSB and credited to the applicant(s) Mortgage Account for onward transmission to Irish Life Assurance plc.

I understand that payments must be paid by the payment due date specified in the Certificate of Membership and failure to pay a payment will result in the insurance cover being cancelled.

I Declaration

This form is my application for cover under Irish Life's normal conditions. I understand that my contract with Irish Life Assurance plc will be based on this declaration, my application form completed, any supplementary questions answered, any statements made to Irish Life's underwriting team in response to any phone calls received and recorded. Or any information I give to a medical examiner acting for Irish Life and all terms and conditions furnished to me by Irish Life. I understand that I must tell Irish Life about any changes in my health or circumstances between the date I applied for life cover and the date my application is accepted.

I have read over the replies to all the questions in this application form and declare that all statements as well as those about tobacco consumption (including any statements written down for me) are true and complete. I have read and understand the notes concerning telling Irish Life about material facts and understand that if I do not tell you all material facts this contract could be void.

I agree that Irish Life may get information from any doctor who at any time has attended me concerning anything which affects my physical or mental health and I authorise them to give Irish Life this information. Irish Life may also get information from any insurance company and I also authorise them to give Irish Life this information. I agree that this authority will stay in force after my death as well as before.

I understand that if any of my previous applications for insurance cover have been turned down or accepted under special terms, that this is noted on a registry administered by the Irish Insurance Federation. I understand that Irish Life may access this information along with other companies as a protection against not being given material facts.

I understand that cover shall not commence until all of the following events have taken place:
(i) this application for cover has been underwritten and accepted by Irish Life,
(ii) the drawdown of the mortgage amount as advised by the Proposer, and
(iii) the first payment has been charged to the mortgage account.

I understand that if Irish Life turns down an application for insurance or accepts it under special terms, Irish Life will note this on a registry administered by the Irish Insurance Federation. Irish Life may share this information with other companies as a protection against not being given material facts and I agree that this information (including any medical data) can be held for six years by Irish Life, even if this application does not result in a plan being issued.

I authorise Irish Life Assurance plc (ILA) and its agents to hold and process information in connection with this contract or transaction. This includes any other information supplied to or obtained by ILA separately. ILA may hold and process this information for administrative, customer care and service purposes. I agree that my personal data can be disclosed 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 the company has a contract as a service provider, to other insurance companies and to other companies in the Company's group.

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) / /

YOU CAN ASK US FOR A COPY OF YOUR FILLED IN APPLICATION FORM.