

# Application Form



# Income Protection Application Form

You should take reasonable care to answer all the questions honestly and to the best of your knowledge. If you do not answer all of the questions fully and accurately, the cover in the event of a claim may be rejected or not fully paid. If you need to make any alterations or wish to add any additional information to this document please contact our Underwriting team immediately on 0800 0931 535 or email [Underwriting@holloway.co.uk](mailto:Underwriting@holloway.co.uk).

## Adviser Contact Details

Adviser Identification (Company Name ) \_\_\_\_\_  
Adviser Name \_\_\_\_\_ FRN No. \_\_\_\_\_  
Email Address \_\_\_\_\_  
Quotation reference number \_\_\_\_\_ Adviser Tel No. \_\_\_\_\_  
Commission Style \_\_\_\_\_ UW Method \_\_\_\_\_  
Holloway Pre Sale Ref \_\_\_\_\_  
Proposed Plan Start Date \_\_\_\_\_  
As soon as possible \_\_\_\_\_ Yet to decide \_\_\_\_\_

**Important Note:** Please ensure you disclose during this application process all information you provided during the pre-sales enquiry. Failure to fully disclose all relevant information could mean that the cover in the event of a claim may be rejected or not fully paid.

If the information disclosed during this application process, or obtained in cases where medical evidence is also required, differs from the information provided during the pre-sale enquiry, we may be unable to stand by any indicative terms offered in that call/email.

## Personal Details

Title \_\_\_\_\_ Surname \_\_\_\_\_ First Name(s) \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_ Post Code \_\_\_\_\_  
County \_\_\_\_\_ Town \_\_\_\_\_  
Daytime Tel No. \_\_\_\_\_ Evening Tel No. \_\_\_\_\_ Mobile No. \_\_\_\_\_  
Email \_\_\_\_\_

## Benefit Details

Benefit required \_\_\_\_\_  
Cover type \_\_\_\_\_ Indexation/escalation of benefit \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Deferred Period \_\_\_\_\_ Age at which plan will cease \_\_\_\_\_  
Date of Birth DD \_\_\_\_\_ MM \_\_\_\_\_ YYYY \_\_\_\_\_ Gender Male \_\_\_\_\_ Female \_\_\_\_\_  
Have you used any tobacco products or nicotine substitutes within the last 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_  
If you have given up in the last 12 months or only smoke occasionally you must answer this question 'yes'

## Occupation Details

What is your main occupation? \_\_\_\_\_ Occupational Class \_\_\_\_\_

Are you employed? \_\_\_\_\_ self employed? \_\_\_\_\_ both employed/self employed? \_\_\_\_\_

Annual Income \_\_\_\_\_ £ \_\_\_\_\_

- If employed, this is your gross annual salary
- If self-employed, this is your share of the pre tax profit
- If Company Director, this is your share of the pre tax profit plus salary

How many hours on average do you work each week? (Must be working or contracted to work 16 hrs or more). \_\_\_\_\_

If you receive sick pay from your employer when you are off work because of sickness or accident, please provide details:

Weeks on full pay? \_\_\_\_\_ Weeks on half pay? \_\_\_\_\_

Is your job predominantly office based / clerical or in one of the following industries: Retail, catering, education or healthcare? Yes No

Do you have a secondary occupation, this can include TA or RAF reservist? Yes No

## Other Insurances

Do you have any existing policies with Holloway Friendly? Yes No

Do you have any existing policies for sickness, disability or accident protection in place or are you applying to any other company? Yes No

## Your Bank Details

You can pay your Direct Debit between 1st and 28th of the month, your Selected Payment Date is \_\_\_\_\_

Did you provide your bank details when submitting this application? Yes No

If not, please call on 0800 0931 535 or email [underwriting@holloway.co.uk](mailto:underwriting@holloway.co.uk) to provide the missing details, or alternatively send us a completed copy of our paper Direct Debit form.

## Initial Assessment Details

1 Are you currently off work, working reduced hours or have you altered your duties due to illness or injury?

2 Do you currently or have you ever had any of the following:

• Heart attack, a stroke (not including TIA/mini stroke) or any disease affecting the arteries of the legs

• Leukaemia, Hodgkin's disease, lymphoma

• Multiple sclerosis, paralysis or any other disease of the central nervous system (the brain, spinal cord and nerves)

- Organ transplant

- Schizophrenia or any other type of psychosis including manic type, bipolar or personality disorder

- Have you ever tested positive for HIV / Aids?

- I confirm I have not currently or ever had any of the above

3 Have you resided in the UK and been registered with a UK NHS GP for the last 3 consecutive years?

4 Are you currently self-isolating or in the last 30 days have you been diagnosed with coronavirus?

5 a What is your height without footwear?

5 b What is your current weight?  
If currently pregnant, please tell us your weight immediately before your pregnancy.

**BMI Details-**

This height to weight ratio is acceptable on standard premium rates

5 c Has your weight changed by more than 3kg or 7lbs within last 12 months?

## Life and Medical Details

1	<p>In the last 3 years have you taken part in any of the following or do you intend to do so within the next 12 months:</p> <ul style="list-style-type: none"><li>- Off road biking or biking with competitions</li><li>- Motor sport</li><li>- Aerial sport</li><li>- Outside climbing or mountaineering</li><li>- Caving or potholing</li><li>- Water sport(except swimming)</li><li>- Winter sport</li><li>- Horse riding</li><li>- Martial arts or any form of fighting</li><li>- Contact sport e.g.rugby, football, ice hockey</li><li>- Shooting</li><li>- Sports at a competitive level</li><li>- Any other extreme sport e.g.bungee jumping, Parkour, free running, power lifting</li></ul>
2	<p>Alcohol consumption please read the following questions:-</p> <ol style="list-style-type: none"><li>1. Do you drink more than 35 units per week?</li><li>2. Have you ever been advised to reduce the amount you drink?</li><li>3. Have you ever had treatment for or received alcohol related counselling?</li><li>4. Have you ever joined an organisation for alcohol abuse or dependence?</li><li>5. Have you ever been told you have any liver damage or abnormal test results?</li></ol>
3	<p>Are you currently smoking tobacco?</p>
3.2	<p>If you don't smoke or use any type of tobacco product, which of the following applies to you?</p>
	<p>a) Life-long non-smoker</p>
	<p>b) Ex-smoker</p>
	<p>c) User of nicotine replacement products in the last 12 months e.g. e-cigs, vaping, patches, chewing gum</p>
4	<p>Have you ever used (inhaled, injected or ingested) any substance that has not been prescribed for you by a doctor?</p>
5	<p>In the last 5 years have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, intravenous drug use, blood transfusions or surgery undertaken outside the EU, Australia, New Zealand or USA)</p>
6 a	<p>In the last 5 years have you resided outside any of the following countries: the UK, Channel Islands, Isle of Man, all other EU countries, Andorra, Australia, Canada, Gibraltar, Hong Kong, Iceland, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA or the Vatican City?</p>
6 b	<p>In the last 5 years have you travelled abroad or do you intend to travel outside of the above countries for any reason other than holidays for more</p>

than 1 month duration?

**7. In the last 5 years have you had or suffered from any of the following:**

- |     |  |
|-----|--|
| 7 a | Any eye condition or ear/hearing condition (sight problems corrected by glasses/ contact lenses or laser eye treatment to correct short/long sightedness can be ignored) or any permanent defect of your sight or hearing  |
| 7 b | <b>Musculoskeletal</b><br><br>I. Any back, neck or spine pain/issues<br><br>II. Any rheumatic, arthritic or muscular complaints, joint complaints including, gout, repetitive strain injury, carpal tunnel syndrome.<br><br>III. Bone fracture?  |
| 7 c | Low mood, bereavement or other loss reaction (a reaction to a loss such as a relationship breakdown or being made redundant), anxiety, stress, depression, insomnia, eating disorder or mental health illness, regardless of whether or not you have seen a doctor or received treatment or counselling of any kind? |
| 7 d | Headaches or migraines requiring you to seek advice or treatment from a doctor.  |
| 7 e | Any condition of the prostate or genital area requiring you to seek medical advice?  |
| 7 f | Allergy requiring prescribed treatment from a doctor or resulted in a hospital admission or require you to follow a special/restricted diet?   |
| 7 g | Asthma or any condition affecting your lungs or breathing including emphysema, bronchitis, sarcoidosis, sleep apnoea (you can ignore any one-off chest infections which you have fully recovered from)?  |
| 7 h | Digestive, bowel, stomach or oesophagus disorders (for example piles, hernia, recurrent dyspepsia, stomach ulcers, polyps, irritable bowel syndrome, colitis, Crohn's Disease or weight loss surgery)  |
| 7 i | Skin conditions which fit into any of the following:<br>a) required referral to a specialist<br>b) mole or freckle that has changed appearance, bled or become painful or itchy<br>c) any lump or growth<br>d) have been caused or aggravated by your work or working conditions.                                    |
| 7 j | Any time off work requiring a medical certificate from your doctor and not covered by the questions already asked?   |
| 7 k | An abnormal blood test result  |
| 7 l | A sexually transmitted infection or are you awaiting the result of such a test?  |

**8. Do you currently have or have you ever had (other than the conditions already covered)**

- |     |   |
|-----|---|
| 8 a | Mental illness including anxiety, stress, depression or any other psychiatric disorder which fits any of the following categories:<br>i) has required hospital treatment<br>ii) has required referral to a psychiatrist<br>iii) have you attempted to end your own life or had suicidal thoughts<br>iv) have you ever self-harmed |
| 8 b | Dizziness, any condition affecting balance or co-ordination, numbness, tingling, loss of memory, paralysis, tremor or facial pain.  |
| 8 c | Chronic fatigue/tiredness, fibromyalgia, myalgic encephalomyelitis (ME), muscle weakness, spasm or any symptoms of the nervous system   |
| 8 d | Diabetes, sugar in your urine, pre-diabetes or gestational diabetes   |
| 8 e | Blood disorder requiring referral to a specialist and/or regular follow up and/or permanent medication.   |
| 8 f | Liver/gallbladder or pancreas issues?   |
| 8 g | Epilepsy or seizure   |
| 8 h | Any condition affecting your thyroid  |
| 8 i | Kidney, urinary or bladder problems requiring referral to a specialist and/or regular follow up and/or permanent medication.  |
| 8 j | Any form of cancer, malignant growth or lesion, brain or spinal cyst/tumour   |
| 8 k | Chest pain, angina, heart enlargement, heart failure, heart valve defect, heart rhythm defect or any other condition affecting the heart, circulation, arteries, veins or any heart surgery   |
| 8 l | High blood pressure and/or raised cholesterol   |
| 8 m | Brain injury/damage, brain haemorrhage, mini stroke or TIA.   |

**9. Other than for the conditions you have already disclosed:**

- |     |  |
|-----|--|
| 9 a | Are you considering getting medical advice or treatment, or are you waiting for any appointments or investigations with your doctor or other health profession?                            |
| 9 b | Are you taking any medication including tablets, lotions, creams, inhaler or spray including alternative therapy or receiving treatment e.g. physiotherapy, chiropractor, counselling etc? |
| 9 c | Have you in the last 5 years been advised to attend a consultation with any medical professional or have you been referred by any medical professional for any tests or investigations?    |
| 9 d | Do you have any physical or mental condition that restricts or causes difficulties in performing the duties of your occupation?  |

9 e In the last 2 years have you been:  
i) subject to medical review with a doctor, medical centre or clinic?  
ii) prescribed any medication or treatment?  
(You do not need to tell us about common colds, influenza, contraception, pregnancy reviews, fertility treatment).

10 Have any of your natural parents, brothers or sisters, before the age of 60, been diagnosed with or died from any of the following:

- Heart attack, angina, coronary artery bypass, stroke / TIA or type 2 diabetes
- Colon or bowel cancer
- Familial bowel polyps (polyposis of the colon)
- Multiple sclerosis
- Polycystic kidneys
- Alzheimer's disease
- Motor neurone disease, muscular dystrophy
- Parkinson's disease
- Huntington's disease
- Cancer of another site (other than colon or bowel)
- Retinitis pigmentosa
- Cardiomyopathy
- Any other hereditary condition
- I don't know, as I was adopted or have no further contact with family members
- No, they have not

11 Please provide the name, address and contact number for your NHS GP, and if relevant your private practice doctor.

12 Is there anything else you wish to tell us about your Health or Lifestyle that hasn't already been covered? Any additional information provided below will be referred to an underwriter for review. So if there is nothing please leave blank or just state NO.



## Mental Health

1

Was this a bereavement reaction or a loss reaction e.g. being made redundant, relationship breakdown?

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## Mental Health Sub

1	Are there any known causes or triggers for your symptoms?	
2	'Please describe the symptoms that you have experienced due to this condition	
3 a)	When did you first start having these symptoms (please include month and year if known)?	
3 b)	When did you last have any of these symptoms (please include month and year if known)?	
3 c)	How often are you (or were you) having symptoms and how long do (or did) they last for?	
4	Have you had or been advised to have any of the following:-	
	• Counselling	
	• Talking therapies	
	• Medication	
	• Time off work	
	• Symptoms are ongoing	
	• Other	_____
5	Have you ever received or been advised to have hospital treatment for this condition, either as an in-patient or out-patient?	_____
6	Have you ever had any suicidal thoughts or have you attempted to end your own life or self-harmed?	_____
7	Have you had to take time off work due to this condition?	_____
8	Overall, how does (or did) work impact your symptoms?	
	• i) Makes things better	
	• ii) Makes things worse	
	• iii) Makes no difference	
8 a)	Please describe how work impacted your symptoms in this way	
9	Were you prescribed or did you take any medication (e.g. sleeping tablets, antidepressants or anti-anxiety medication)?	

9 a) For each medication, please confirm:-  
- The date you first started taking it  
- The dosage - The date you stopped taking it - If you were prescribed medication but chose not to take it please confirm which medication this was and why:

Medication 1:

Medication 2:

Medication 3:

9 b) Did you take your medication(s) for as long as recommended by your doctor?

9 c) Please confirm which one and why

10 Are you are still taking any of the above medications? \_\_\_\_\_

11 Since you stopped taking all of your medication, have you experienced a recurrence of your initial symptoms or any symptoms of low mood, anxiety/stress or depression or needed to take time off work?

12 Were you advised to or did you attend talking therapies / counselling?

12 a) Type of therapy you were/ are having

12 b) Date you started the therapy (month and year if known)

12 c) How often you saw / are seeing the therapist

12 d) Date therapy stopped (month and year if known or if continuing please state "ongoing")

13 When things are difficult do you tend to (select the best match for you):-

- Feel like yourself after a day or so
- Feel like yourself after a few days
- Feel like yourself after a week or so
- Find it takes longer to feel like yourself

14 When things are difficult do you tend to (select the best match for you):-

- Find change easy to handle
- Perhaps find change a bit harder to handle
- Tend to struggle to adapt to change

## Mental Health

1 Are there any known causes or triggers for your symptoms?

1 a) Please give more information on the triggers or causes

1 b) If work is / was a trigger or cause please confirm:

i. What were the circumstances?

ii. Whether or not you have you changed jobs? If not explain what changed to help you overcome your symptoms triggered by your work.

2 Please describe the symptoms that you have experienced due to this condition

3 a) When did you first start having these symptoms (please include month and year if known)?

3 b) When did you last have any of these symptoms (please include month and year if known)?

3 c) How often are you (or were you) having symptoms and how long do (or did) they last for?

4 Have you had or been advised to have any of the following:-

• Counselling

• Talking therapies

• Medication

• Time off work

• Symptoms are ongoing

• Other

5 Have you ever received or been advised to have hospital treatment for this condition, either as an in-patient or out-patient?

\_\_\_\_\_

6 Have you ever had any suicidal thoughts or have you attempted to end your own life or self-harmed?

\_\_\_\_\_

7 Have you had to take time off work due to this condition?

\_\_\_\_\_

8 Overall, how does (or did) work impact your symptoms?

• i) Makes things better

• ii) Makes things worse

- iii) Makes no difference

8 a) Please describe how work impacted your symptoms in this way

9 Were you prescribed or did you take any medication (e.g. sleeping tablets, antidepressants or anti-anxiety medication)?

9 a) For each medication, please confirm:-  
- The date you first started taking it  
- The dosage  
- The date you stopped taking it  
- If you were prescribed medication but chose not to take it please confirm which medication this was and why:

Medication 1:

Medication 2:

Medication 3:

9 b) Did you take your medication(s) for as long as recommended by your doctor?

10 Are you are still taking any of the above medications? \_\_\_\_\_

11 Since you stopped taking all of your medication, have you experienced a recurrence of your initial symptoms or any symptoms of low mood, anxiety/stress or depression or needed to take time off work? \_\_\_\_\_

12 Were you advised to or did you attend talking therapies / counselling?

12 a) Type of therapy you were/ are having

12 b) Date you started the therapy (month and year if known)

12 c) How often you saw / are seeing the therapist

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13 When things are difficult do you tend to (select the best match for you):-

- Feel like yourself after a day or so
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- Find it takes longer to feel like yourself

14 When things are difficult do you tend to (select the best match for you):-

- Find change easy to handle
- Perhaps find change a bit harder to handle

- 
- Tend to struggle to adapt to change
-

# Data Protection Notice

## Using your personal information

The Original Holloway Friendly Society (Holloway Friendly) is the Data Controller for the information collected.

Your personal information will be used by Holloway Friendly to assess your application and administer your plan. Any lifestyle and medical information which is collected in connection with your application will be used for 'underwriting', that is to see if we can offer you a plan, what cover we can offer and how much it will cost. Our systems will not allow your application to proceed if you have certain medical conditions or you tell us that you do certain jobs where we will be unable to offer you a policy. You have the right to challenge a decision made in this way (see your rights below).

We also use your personal information to administer your plan and if you make a claim. We use your information to fulfil our legal and regulatory obligations and to improve our products and processes. To ensure we charge a fair price, we will ask you whether close family members have suffered from certain medical conditions. You can see more details on how we use your information including details of the legal basis for using your information in our Privacy Notice which can be viewed at [www.holloway.co.uk/privacy-notice](http://www.holloway.co.uk/privacy-notice).

Depending on what you tell us, we may need need to contact doctors you have consulted to consider your application. You do not have to give us your consent, and may withdraw it, but if we cannot obtain this information we may not be able to offer you a plan, or it may cost more than it otherwise would have.

If your application does not proceed, Holloway Friendly may hold a record of the application for up to three years. Otherwise, we will hold the data we need for up to six years after your plan finishes to meet our regulatory obligations and so we can deal with any queries or complaints you may subsequently have.

## Which Third parties receive Your Data?

Holloway Friendly will not sell your information to another company or use it to market the products or services of other companies to you. We do share information with third parties for various reasons. More information about the third parties we share data with is contained in our Privacy Notice. Your information, including sensitive medical information, will be shared with carefully selected third parties who supply specialist services to Holloway Friendly such as conducting telephone interviews, assisting with underwriting, and our Internal Auditors, Ernst and Young LLP and our External Auditors PricewaterhouseCoopers. Your Information and where appropriate copies of correspondence will be given to your financial adviser/insurance intermediary to enable them to give you advice and/or fulfil their regulatory obligations. If at any time you do not want us to send your information to your financial adviser/insurance intermediary in the future, please let us know. A copy of your personal information, including sensitive medical information may be given to a reinsurance company, another company that shares the risks that people will claim under insurance policies, should we choose to reinsure part of our business. Holloway Friendly will only disclose your personal information in accordance with Data Protection legislation, including the General Data Protection Regulation (GDPR) and will only allow third parties we appoint to send your information to countries outside the European Union when appropriate safeguards are in place.

To protect Member funds, to prevent and detect fraud, we sometimes access publicly available information about claimants. These sources include social media and electoral roll data. If fraud is suspected, we may decide to pass information to fraud prevention agencies or employ covert surveillance methods. More information about our approach to preventing fraud is contained in our Privacy Notice.

Telephone calls may be monitored and recorded to help staff training, customer service and for the purposes of security and fraud prevention.

## Your Rights

- **Access your information** and some details of how we use it such as the purpose of the processing, the categories of information that we hold, to whom it has been disclosed and how long it will be stored. We do not normally make a charge for supplying this information. We will agree with you how to securely provide access to your information, in writing or by electronic means, where this is possible.
- **Data portability.** For some information, typically the personal information you supplied to us, you have the right to ask that we send it to a third party you have chosen. The third party will then become responsible for looking after it.
- **Rectification.** We try and keep the personal information we have about you up to date and accurate. However, if it is not correct or is incomplete, you can ask us to correct it or add other information to it.
- **Erasure.** This has sometimes been called 'the right to be forgotten' in the press. You can ask us to delete some of your information if you think we no longer need it for the purpose for which we collected it or where we are only processing it with your consent and you wish to withdraw consent. There may be reasons why we cannot delete your information e.g. if

we are obliged to keep it for legal or regulatory reasons. Where this is the case we will tell you, and indicate how long we need to keep it.

- **Restriction of processing.** You can ask us to stop processing your information in certain situations e.g. if you are concerned your information is inaccurate and you want us to verify it or you don't think we have the right or need to process it, but don't want us to delete it.
- **Right not to be subject to automated decision making.** Our systems will not allow your application to proceed if you have certain medical conditions or you tell us that you do certain jobs where we will be unable to offer you a policy. You have the right to object to automatic decisions made in this way and if you do so, one of our team will reconsider your application.

If you have any queries or concerns about how we handle your information, or want to exercise your rights, please contact us at: [Dataprotectionofficer@holloway.co.uk](mailto:Dataprotectionofficer@holloway.co.uk). Our full Privacy Notice can be viewed at: [www.holloway.co.uk/privacy-notice](http://www.holloway.co.uk/privacy-notice).

## Disclosure

You must remember that all items of information asked for in this form, the Lifestyle & Medical questions and the telephone interview are taken into account when assessing your cover. As we rely on the information you provide, you must take care to ensure the information you provide is correct, so you need to answer each question fully and truthfully.

The Society's Memorandum, rules and schedule relating to your application can be obtained by visiting our website [www.holloway.co.uk](http://www.holloway.co.uk)

## Continuing duty to disclose

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

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

Disclosures to any of the questions, medical or otherwise are of equal importance and failure to advise us may result in a claim being rejected or not fully paid

## Requesting a Medical Report

We may need to get information from your doctor to support or check your answers you have given in your application. If we do, you will need to sign a consent form Reports Act (AMRA) 1988. We will contact you to obtain your consent if we need to request a report. This consent will provide details of your legal rights over any report requested.

## Genetic Testing

If you have had a genetic test, you only have to tell us if this application, when added together with any other cover you have for income protection, is above the following limit:

- £30,000 annual benefit for Income Protection.
- Above this limit you may need to give information about certain test results when applying for insurance. Only genetic test results which have been approved by the Government's Genetics and Insurance Committee will be used.

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

## Declaration and Consent

We may need to get information from your doctor to support or check your answers you have given in your application. If we do, you will need to sign a consent form Reports Act (AMRA) 1988. We will contact you to obtain your consent if we need to request a report. This consent will provide details of your legal rights over any report requested.



- I confirm that I have answered the questions in this form and any additional forms honestly and accurately. The information I have provided in response to the questions is, to the best of my knowledge and belief, true and I have taken reasonable care to ensure those answers are correct.
- I am aware that if I haven't answered the questions correctly, my plan may be cancelled, or it's terms may be changed or a claim may be rejected or not fully paid.
- I consent to you arranging and conducting a telephone interview with me and understand that the information provided forms part of the application for insurance. A copy of the Terms and Conditions and completed application form are available upon request.
- I confirm I have read and understood the Disclosure and the Continuing Duty to Disclose information in this form.
- I also fully understand in the event of a claim, my limitations to benefit entitlement as stated in the Key Features Document.
- I agree that Holloway Friendly may use my personal information (including sensitive medical and lifestyle data) to see if Holloway Friendly can offer me a plan and on what terms. I understand that I can withdraw my consent at any time before being accepted for a plan by contacting Holloway Friendly.
- I agree that a copy of this application can be treated as the original for all purposes
- I understand that after I have taken out a plan Holloway Friendly will use my personal information for the purposes outlined in its Privacy Notice and that withdrawing my consent to processing at this time will not result in all processing ceasing.

A copy of the Terms and Conditions and completed application form are available upon request.

**I confirm that I have provided to my client Key Features, a quotation and our Declaration Notice (Data Protection Notice, Genetic Testing Statement and Duty of Disclosure).**

## Contact us.

We're here to help.

### Address

Holloway House  
71 Eastgate Street  
Gloucester GL1 1PW

 **0800 0931 535**

 [underwriting@holloway.co.uk](mailto:underwriting@holloway.co.uk)

 [www.holloway.co.uk](http://www.holloway.co.uk)

### We're here

**Monday - Friday** 9.00am to 5.00pm