OFFICE USE ONLY	INTRODUCER		PFA/IFA NO.		ASS/NOM NO. 1		ASS/NOM NO. 2		SCORVIE	

DATE OF MATURITY 1	DATE OF MATURITY 2	DATE OF ENTRY 1	DATE OF ENTRY 2	POLICY NUMBER 1	POLICY NUMBER 2	PROP NO. 1	PROP NO. 2	PROP INPUT SIGNED	PROP DOC PRODUCED	NEW BUS DOC CHKD

(a) Personal details of life assured:

RED ROSE ASSURANCE
Making Mutuality Meaningful

Please complete fully in block capitals Life Proposed		Proposer / 2nd Life Assured (Joint Life, Taxable only)	
TITLE:	SURNAME:	TITLE:	SURNAME:
FORENAMES:	DOB:	FORENAMES:	DOB:
ADDRESS:		ADDRESS:	
POST CODE:	OCCUPATION:	POST CODE:	OCCUPATION:
MARITAL STATUS:	PLACE OF BIRTH:	MARITAL STATUS:	PLACE OF BIRTH:
TEL No:	MOBILE NO:	TEL No:	MOBILE NO:
EMAIL ADDRESS:		EMAIL ADDRESS:	

(b) Type of policy:

TABLE NO.	POLICY TYPE.	SUM ASSURED £	TABLE NO.	POLICY TYPE.	SUM ASSURED £
TERM OF YEARS.	PREMIUM.	FREQUENCY	TERM OF YEARS.	PREMIUM.	FREQUENCY

(c) Details of other Tax-Exempt Policies (include any other proposals currently under consideration):

COMPANY/SOCIETY.	PREMIUM	FREQUENCY	TERM	COMPANY/SOCIETY.	PREMIUM	FREQUENCY	TERM
SUM ASSURED.	POLICY NO.	POLICY DATE.		SUM ASSURED.	POLICY NO.	POLICY DATE.	

(d) Medical and other information:

1. Please give the name and full address of your regular doctor.

NAME	ADDRESS	NAME	ADDRESS
	POST CODE		POST CODE
STATE YOUR HEIGHT AND WEIGHT _____FT _____INS OR _____MTRS _____ST _____LBS OR _____KGS		STATE YOUR HEIGHT AND WEIGHT _____FT _____INS OR _____MTRS _____ST _____LBS OR	

2. Have any of your family (parents, brothers or sisters) died? Or suffered from any serious illness?

NO ☐ YES ☐ NO ☐ YES ☐

PLEASE GIVE DETAILS OF THEIR RELATIONSHIP TO YOU, AGE, NATURE OF THEIR ILLNESS, CAUSE OF DEATH, ETC.

3. Have you ever been an in-patient at a hospital, clinic or nursing home for any illness or condition which required medical, surgical or psychiatric advice, treatment, investigation, tests or x-rays?

NO ☐ YES ☐ NO ☐ YES ☐

PLEASE GIVE DETAILS OF YOUR VISITS AND TREATMENT, FOR EXAMPLE, THE DATE OF VISIT, THE DOCTOR CONSULTED AND THE REASON FOR YOUR VISIT

4. Have you seen any doctor in the last 5 years concerning any illness or condition?

NO ☐ YES ☐ NO ☐ YES ☐

PLEASE EXPLAIN THE REASON FOR YOUR VISIT(S). PLEASE GIVE THE NAME AND ADDRESS OF THE DOCTOR SEEN (UNLESS ALREADY GIVEN EARLIER IN THIS FORM)

5. Are you taking tablets, medicine or drugs of any kind, whether prescribed or otherwise, or receiving any form of treatment

NO ☐ YES ☐ NO ☐ YES ☐

WHAT MEDICATION ARE YOU RECEIVING?

6. Have you tested positive for HIV/AIDS or HEPATITIS B or C, or have you been tested or treated for any sexually transmitted diseases or are you awaiting the results of such tests?

NO ☐ YES ☐ NO ☐ YES ☐

PLEASE GIVE DETAILS

7. Do you take part in any hazardous activities or do you expect to do so in the future. The activities could include for example, private flying, mountaineering, hang gliding or pot holing.

NO ☐ YES ☐ NO ☐ YES ☐

PLEASE GIVE DETAILS

Application form for adult tax-exempt/able savings and whole of life

8. Have you been resident or travelled outside the UK for any period of more than two months in the last 5 years? If you expect to do so in the future, tick 'yes'

NO ☐ YES ☐ NO ☐ YES ☐

PLEASE GIVE DETAILS

9. Do you drink alcohol?

NO ☐ YES ☐ NO ☐ YES ☐

HOW MANY UNITS DO YOU DRINK PER WEEK? ONE UNIT IS A PUB MEASURE OF WINE OR SPIRITS OR A HALF PINT OF BEER, LAGER OR CIDER?

10. Do you smoke cigarettes or have you smoked any cigarettes in the past twelve months? If you intend to smoke cigarettes in the future tick 'yes'. If you only smoke cigars or a pipe tick 'no'.

NO ☐ YES ☐ NO ☐ YES ☐

HOW MANY CIGARETTES PER DAY?

11. Has any proposal for life, sickness or permanent health assurance on your life ever been declined, postponed, withdrawn or had special terms imposed?

NO ☐ YES ☐ NO ☐ YES ☐

GIVE DETAILS OF COMPANY/IES SOCIETY/IES AND DATE(S)

12. Any other comments or information you may feel relevant.

(e) **Your rights under the Access to Medical Reports Act 1988:** Not applicable in Northern Ireland, the Isle of Man or Channel Islands

Depending on your individual circumstances and insurance requirements, we may need to apply for a medical report from a Doctor who has cared for you. Before giving your consent for us to do this, by completing and signing the Declaration on the application form, you should read this carefully, as it sets out the procedure for dealing with medical reports and your rights under the Access for dealing with medical reports and your rights under the Access to Medical Reports Act 1988. These are set out in more detail below, but the four main points are as follows:-

1. You can withhold your consent
2. You can see the report before it is sent to us, or during the six months thereafter .
3. You can ask the Doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the doctor does not agree, you may append your comments.
4. The doctor can withhold the report – or any part of it – from you, if he/she thinks you would be harmed by seeing it.

You do not have to give your consent but if you withhold it, we will be unable to proceed with your application.
If you do give consent, you can say whether you wish to see the report and, if so, whether you wish to see it before or after it is sent to our Chief Medical Officer. In any event, we will notify you if we apply for a report and inform your doctor before the report is sent to us.
If you wish to see the report, you have 21 days in which to arrange with the doctor to see it. The faster you act, the faster your application can be considered.

Once you have seen a report before it is sent to us, the doctor cannot submit it until you have given the doctor your consent to do so.
Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy for up to six months after it is supplied, upon your request.
If you ask the doctor for a copy of the report, the doctor can charge you a reasonable fee to cover the costs.
You may write to the doctor, asking him/her to amend any part of the report upon which you and the doctor disagree, and which the doctor is not prepared to alter, you can have a statement of your views attached to the report.
The doctor can withhold any part of the report from you if, in his/her opinion:-

i to do so would be likely to cause serious harm to your physical or mental health or that of others, or indicate the doctor's decisions or intentions towards you,
Or
ii disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a Health professional involved in caring for you.

In such cases, the doctor must notify you and you will be limited to seeing only a remaining part of the report. If it is the whole report, which is affected, the doctor must not send it to us unless you give your consent.

I understand my rights under the Access to Medical Reports Act 1988 as described in section (e) and I consent to the society seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health, or seeking information from any insurance company to which a proposal has been made for insurance on my physical or mental health, or insurance on my life and I authorise the giving of such information. I agree that a copy of this consent shall have the validity of the original.

I/We do NOT wish to see the medical report before it is sent to the society TICK ONE BOX ONLY ☐

I/We wish to see the medical report **before** it is sent to the society and I/WE understand this may delay acceptance of my proposal ☐

Signature 1: ..... **Date:** ..... **Signature 2:** ..... **Date:** .....

(f) **Declaration:** To be made to the Proposer

I/We declare that to the best of my knowledge and belief the above statements are true and that no material facts have been withheld. I/We agree that these statements together with any statements made by me to the Society's medical examiner shall form the basis of the proposed contract of assurance between me and The Red Rose Friendly Society Limited and I will be bound by the terms and condition of the policy and the rules of the society from time to time in force. I/We apply for membership of the society, and understand that the assurance will not commence until the policy has been delivered to me and the first premium paid and that any such payment will be returned if the proposal is not accepted by the Society.

NOTE: Failure to disclose material facts may affect the benefits payable under your policy. Material facts are those, which an insurer would regard as likely to influence the assessment and acceptance of a proposal. If you are in doubt as to whether certain facts are material, they should be disclosed. A copy of the policy conditions and of this proposal form will be available upon request.

FURTHER DECLARATION BY LIFE PROPOSED

I consent to the society seeking information, before or after my death, from any doctor who attended me or from any assurance office to which a proposal has been made for assurance on my life and I authorise the giving of such information.
I confirm that if any information I have in this application changes before cover commences, I will inform you immediately in writing of the alterations and understand that a failure to do so may affect the benefits payable.

Signature 1: ..... **Date:** ..... **Signature 2:** ..... **Date:** .....

OFFICE USE ONLY

CLAIM
Mode of exit .....
Date of exit .....
Amount paid:£ .....
Claim number .....

WHEN COMPLETED, INITIAL & DATE
Claim value when checked .....
Claim docs checked.....
Cheque Number.....
Input claim details .....

FREE POLICY
Lapse Date.....
Lapse value.....
Withdrawal date.....
Withdrawal Number .....
Claw back: yes/no £.....
Comp input .....

Name of IFA/PFA .....
I recommend that this proposal be: Accepted ☐ Declined ☐
Reason.....
Special terms & Conditions .....
CCTL/BDM.....
Date.....

application form for adult tax-exempt/able savings and whole of life