For office use only

Ref ______________________

My Earnings Insurance (MEI)

Application Form

Dear Applicant,

Please complete this form in black ink using block capitals. Answer all questions and where applicable tick ☑ your choice. Space for any additional information is provided on page 18.
There is a notes section starting on page 21 which provides further information on how to complete this form.

A.Can I apply for My Earnings Insurance?

1.	Are you 18 or over and have not yet had your 55th Birthday?	Yes ☐ No ☐
2.	Do you live in the UK?	Yes ☐ No ☐
3.	Are you currently registered with a UK Doctor?	Yes ☐ No ☐
4.	Have you been registered with a UK Doctor for the last five years?	Yes ☐ No ☐
5.	Are you currently actively working and not employed on a zero hours contract?	Yes ☐ No ☐
6.	Are you employed or self-employed earning at least £6,400 per year and working 16 hours or more per week?	Yes ☐ No ☐
7.	Are your earnings taxable in the UK?	Yes ☐ No ☐
8.	Can you confirm that you are not awaiting any medical tests or investigations or the results of these?	Yes ☐ No ☐
9.	Can you confirm that you do not work outside of the UK for more than eight weeks in a calendar year?	Yes ☐ No ☐

If you have answered 'yes' to all of the above questions you can apply for My Earnings Insurance.

Please now read and sign this declaration before completing this form.

- You are applying for an income protection insurance contract and it is very important that you answer all the questions as fully and honestly as possible as they are relevant and important and you are responsible for all the answers given. Please complete this form yourself, but if your Financial Adviser completes it then you remain responsible for the accuracy and completeness of the answers given. If you are unsure about any question or your answer, feel free to contact us.
- Your answers to the questions in this application form provide us with material facts which enable us to decide if we can offer you a contract of insurance and if so on what terms. The Society will rely on what you tell us, so please do not assume that we will clarify or confirm the information provided. If you do not answer all questions fully and honestly this could result in your application being declined, your contract being cancelled or any future claims being refused and any paid benefit to you being recovered.
- The Society reserves the right to postpone or decline your application.

I hereby declare that to the best of my knowledge and belief the answers to the questions will be true and correct.

Signature of Applicant ______________________

Date ☐☐ / ☐☐ / ☐☐☐☐

B. Your personal details

1. Have you previously applied to Cirencester Friendly for Membership or are you a current or past Member of the Society? Yes ☐ No ☐

   (If 'yes' please provide Membership or previous reference number)

2. Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ *(please specify)*

   First Name(s) Surname

3. Address

   Postcode

4. Home Telephone Number

   Mobile Telephone Number

   Work Telephone Number

5. Email Address

6. Date of Birth / /

7. Country of Birth

8. If you were not born in the UK, how many years have you lived here?

9. Are you currently moving home or proposing to change your address in the near future? Yes ☐ No ☐

   (If 'yes' please provide your anticipated moving date and your new address)

   Moving Date / /

   New Address

   Postcode

10. Please provide the name and address of your usual Doctor

    Name

    Address

    Postcode Telephone Number

11. In the future the Society might like to contact you regarding products or services we offer. Your details will not be shared with any third parties for marketing purposes (please refer to page 19 for details of Data Protection Guidelines). If you do not want to receive the information, please tick this box ☐ If you would like to be informed by email, please tick this box ☐
    We may occasionally contact you by SMS purely in relation to the administration of your contract.

C. Your occupation

1. Are you currently off work, working reduced hours or had your duties altered due to illness or injury? Yes ☐ No ☐

   (If 'yes' please give details but please note if you are not currently working we are unable to consider your application)

2. What is your **main occupation**? *(Note 1)*

3. How long have you been employed in your main occupation? Years Months

4. Do you have any other occupations, vocations, work or activities from which you receive earnings or payment? Yes ☐ No ☐

(Please provide details including your earnings from these sources)

5. Are you Employed? ☐ Self Employed? ☐ Just in Partnership? ☐ A Company Director? ☐ Other? ☐

(If you are a mix of Employed and Self Employed or 'other' please provide details below)

6. Are you on a Fixed Term Contract? *(Note 2)* Yes ☐ No ☐

(If solely self-employed please tick 'no') *(If 'yes' please provide the following information)*

Fixed Term Contract Start Date ☐☐ / ☐☐ / ☐☐☐☐

Fixed Term Contract End Date ☐☐ / ☐☐ / ☐☐☐☐

7. In a typical week how many hours do you spend doing the following types of activity as part of your occupation?

	Main Occupation	Other Occupations
Manual (physical work done with your hands)	Hours	Hours
Supervisory (giving instructions to others)	Hours	Hours
Administrative (involved in paperwork)	Hours	Hours
Other (anything not covered above)	Hours	Hours
Total	Hours	Hours

(If you have selected 'other' above please provide details of the tasks involved)

8. Will you work outside the UK in any of your present occupations? Yes ☐ No ☐

(If 'yes' please provide the following details. Please include details for all your current occupations as detailed in questions 2 and 4 of this section)

Where?

For how long?

How often?

9. In the last two years have you had any time off work through illness or injury? Yes ☐ No ☐

(If 'yes' please complete the following)

Illness/Injury	Time off	Month	Year

(If you need more space please use page 17)

10. In the last two years other than for holiday or time off work due to illness or injury, have there been any times when you have not worked continuously in your main occupation? Yes ☐ No ☐

(If 'yes' please provide dates, length of time off and the reason below)

11. Using Table (a) or (b) below please tell us about your earnings from your main occupation in the last 12 months.

Table (a)

Employed (including the Director of a Private Limited Company)					
Gross Basic Pay (Gross Annual Salary)	**Overtime Pay**	**Bonus/ Commission/ Incentive Pay**	**P11D Benefits**	**Dividends***	**Total**
£	£	£	£	£	£

**These can be included provided there are not more than 3 other Shareholder Directors.*

Table (b)

Self Employed or in a **Partnership**
Taxable Profit from Business (Not Net Profit but what you declare as total taxable profits on your tax return)
£

If you have any other occupations please provide the same details on the additional information on page 17

12. In the event of a claim you will be asked to provide evidence of your earnings for the preceding 12 months. *(See Note 3 on page 21 for details of the evidence we will require)*

Will you be able to prove your earnings as detailed in Question C11 above should you need to make a claim? Yes ☐ No ☐

(If 'no' please tell us why not)

D. Your income protection needs

1. Have you received a **Key Facts Document** for My Earnings Insurance? Yes ☐ No ☐

(You will need this document to help you complete this section of the Application Form. If you have not received a copy please ask your Financial Adviser or contact the Society)

2. Using Table (a) or (b) below please tell us about your continued earnings from your main occupation if you are off work due to illness or injury.

Table (a)

Employed (including the Director of a Private Limited Company)	Do these earnings continue if you are off work due to illness or injury?	How much would you continue to receive?	How often would you continue to receive these earnings? (e.g. monthly, weekly etc)	How long would you continue to receive these earnings? (e.g. 1 month, 1 week etc)
Gross Basic Pay (Gross Annual Salary)	Yes ☐ No ☐	£		
Overtime Pay	Yes ☐ No ☐	£		
Bonus/Commission/ Incentive Pay	Yes ☐ No ☐	£		
P11D Benefits	Yes ☐ No ☐	£		
Dividends*	Yes ☐ No ☐	£		

**These can be included provided there are not more than 3 other Shareholder Directors.*

Table (b)

Self Employed or in a **Partnership**				
Taxable Profit from Business (Not Net Profit but what you declare as total taxable profits on your tax return)	Do these earnings continue if you are off work due to illness or injury?	How much would you continue to receive?	How often would you continue to receive these earnings? (e.g. monthly, weekly etc)	How long would you continue to receive these earnings? (e.g. 1 month, 1 week etc)
	Yes ☐ No ☐	£		

Please use this space to provide any additional information about your continuing income should you be unable to work due to illness or injury including any continued earnings you would receive from any other occupations.

3. With reference to what you have told us in D2 about the length of time and amount you continue to get earnings from your main or any other occupations you have, when would you like benefit to start?

Please Note

Before you make your selection you cannot pick a period you want benefit to commence unless you anticipate a reduction in your earnings from that point onwards. If you do not have a reduction in your earnings you will not be entitled to benefit and may find you have been paying for something you cannot claim for.

Table (a)

For Single Periods Of Cover			
Benefit to commence	Selection (please tick 1 choice only)	Amount of benefit Weekly	or Annually
From Day One		£	£
Deferred for 4 weeks		£	£
Deferred for 8 weeks		£	£
Deferred for 13 weeks		£	£
Deferred for 26 weeks		£	£
Deferred for 52 weeks		£	£

OR

Table (b)

For Split Periods Of Cover *(note 4)*			
Benefit to commence	Selection (please tick 2 choices only)	Amount of benefit Weekly	or Annually
From Day One		£	£
Deferred for 4 weeks		£	£
Deferred for 8 weeks		£	£
Deferred for 13 weeks		£	£
Deferred for 26 weeks		£	£
Deferred for 52 weeks		£	£

4. Do you require Level Premiums ☐ or Annual Escalating Premiums ☐ ? *(Note 5)*

5. If you have selected a deferred period *(Question 3)*, would you like to add Severe Injury Cover? *(Note 6)* Yes ☐ No ☐
(If 'yes' please indicate which deferred period you would like to add this to)
1st deferred period ☐ 2nd deferred period ☐ Both ☐

6. Would you like to help maintain the value of the Health Benefit you may receive in the future by adding Indexation to your contract? *(Note 7)* Yes ☐ No ☐

7. At what age would you like your contract to end? Occupational Retirement Age *(Note 8)* ☐ or at age 70 ☐

8. When would you like your contract to start? 1st ☐ 7th ☐ 14th ☐ 21st ☐ 26th ☐ ASAP ☐ Month ☐
(If you leave this blank we will start your contract on the next available start date)
Your initial premium will be collected at the first available opportunity and thereafter will be collected on the monthly anniversary of your start date.

9. For a small additional premium you have the option of applying for the following 'My Extra Benefits' alongside your income protection contract;

Fracture & Hospitalisation Benefit ☐ and/or Working Life Death Benefit ☐

Please refer to the My Extra Benefits Key Facts Document. If you have not received a Key Facts Document please ask your Financial Adviser or the Society for a copy.

10. If you have selected the Working Life Death Benefit option, you may wish to complete the below. Otherwise we would pay the deceased estate.

I (FULL NAME)

hereby nominate

Of the address

to receive the benefit payable at my death, under the rules of the Society.

E. Other insurance

1. Have you had an application for life assurance, income protection, disability insurance, accident or critical illness insurance, turned down, postponed or made subject to special terms? Yes ☐ No ☐

(If 'yes' please give the reason, type of cover, date (year) and terms of the offer)

2. Do you currently have or are you applying for cover for illness or injury with any other insurer? Yes ☐ No ☐

(If 'yes' please give the name of the insurer, type of insurance)

Will this cover be cancelled? Yes ☐ No ☐

3. Have you made any claims on income protection, mortgage protection, payment protection, critical illness, waiver of premium, personal sickness and/or accident insurance contracts that you have currently or previously had? Yes ☐ No ☐

(If 'yes' please provide details with approximate dates (year), durations and reason for claim)

4. Have you made any claims for compensation in relation to an illness, injury or accident? Yes ☐ No ☐

(If 'yes' please provide details with approximate dates, outcome and reason(s) for the claim(s))

F. Your health and lifestyle

1. In the event of our needing to collect further or medical information from you are you happy to provide this by telephone? *(Note 9)* Yes ☐ No ☐

Please Note: If you agree to provide information by telephone you do not need to complete the remainder of this section F. If you tick 'no' you must complete section F in full *(Note 10)*

In some circumstances collection of medical information by telephone or from your doctor is compulsory. *(Note 10).*

2. What is your height and weight? (Clothed without shoes) *(Please measure and weigh yourself before completing this question)*

Height ☐ ft ☐☐ ins or ☐☐☐ cms Weight ☐☐ st ☐☐ lbs or ☐☐☐ kgs

3. What is your typical weekly consumption of Alcohol ☐☐☐ units and Tobacco/Cigarettes ☐☐☐

1 pint standard lager/beer = 2 units, a 125ml (small) glass of wine = 1.5 units, a 25ml measure of spirits = 1 unit.

4. At anytime have you been advised to reduce your consumption of alcohol or tobacco or received medical advice, counselling or treatment in connection with alcohol, tobacco or other drug abuse? Yes ☐ No ☐

(If 'yes' please provide the following details a) year b) by whom c) why?)

5. Do you use or have you used recreational drugs or drugs other than for their prescribed purposes or any substance other than for its stated purposes, including 'legal highs'? Yes ☐ No ☐

(If 'yes' please advise a) drug b) dates and durations used c) frequency of use)

6. Do you currently, or have any intention, of engaging in 'Hazardous Activities'? *(Note 11)* Yes ☐ No ☐

If 'yes' please provide the following details:

What Hazardous Activity do you participate in?	
How often do you engage in this activity?	

At any time have you been injured as a result of the activity referred to above? Yes ☐ No ☐

Please use this space to provide details of the injury you suffered as a result of this activity:

Please complete the tables below to the end of page 16 to show whether you have had or received treatment, had tests, checkups or advice relating to the condition in each of the three time periods set.

Please Note

We will use the information you provide on this application to assess your eligibility for My Earnings Insurance.

It is important that throughout the Application Form you have answered the questions completely and truthfully as failure to do so may result in a future claim for Health Benefit being declined or reduced.

Please provide all of the information required. Do not presume we will check or clarify anything with you or any medical practitioner.

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
7. Bones, muscles, tendons, ligaments and cartilage. Have you had: a) Arthritis (including rheumatoid arthritis)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Gout?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
c) A diagnosis of osteoporosis / osteopenia?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
d) Fibromyalgia?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
e) Any disease, condition or disorder of the back, back pain or neck including sciatica and ankylosing spondylitis or any surgery to your neck, back or other joints?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
f) Repetitive strain injury or any other symptoms, including pain or limitations affecting the ligaments, bones, tendons, cartilage or muscles?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
g) Any disease, condition or disorder of the joint(s) including hip, shoulder, knee, wrist or any other joint?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
8. Blood. Have you had: Any condition, disorder, or abnormality of the blood including anaemia or abnormal blood test results?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and dates. 4. Time off work and when. 5. Whether blood results are now normal and if so from when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
9. Blood Pressure. Have you had: High or low blood pressure?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Which condition. 2. Dates and durations. 3. Treatment, when commenced and whether still being taken. 4. Whether medication has been changed in the last 12 months and if so how. 5. Time off work and when. 6. Last reading if known.*
10. Bowel Have you had: a) Piles or haemorrhoids, coeliac disease, irritable bowel syndrome (IBS)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Crohn's disease, ulcerative colitis or any other bowel condition(s)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
11. Broken Bones Have you had: A broken bone or fracture?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Dates. 2. Which bone (if applicable state right or left). 3. Whether a full recovery has been made. 4. Whether surgery carried out and whether metalwork still present or if removed, when.*
12. Cancer and Tumours Have you had: Cancer, leukaemia, Hodgkin's disease, lymphoma, spinal, acoustic or brain tumours (whether malignant or benign)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
13. Cholesterol. Have you had: Raised cholesterol?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Dates and durations. 2. Treatment, when commenced and whether still being taken. 3. Whether medication has been changed in the last 12 months and if so how. 4. Time off work and when. 5. Last reading if known.*
14. Circulation Have you had: a) Varicose veins, a single episode of deep vein thrombosis (DVT), poor circulation or chest pain?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Stroke, mini-stroke, transient ischaemic attack (TIA) or a brain haemorrhage including subarachnoid haemorrhage?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
c) Any disease, condition or disorder of the arteries in the legs or of the aorta, such as varicose veins, more than one episode of deep vein thrombosis or thrombophlebitis (swelling of a vein caused by a clot)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
15. Depression/Anxiety Have you had: a) Depression, anxiety, stress, low mood, panic attacks, bereavement reaction, anger management, fatigue, insomnia or eating disorders?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Any condition which has required referral to a psychiatrist, psychologist or counsellor?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
16. Diabetes Do you have diabetes?	
Currently Yes ☐ No ☐	*1. Date diagnosed. 2. Treatment. 3. Time off work and when. 4. Latest HbA1c or IFCC result (and date). 5. Whether there have been complications such as eye, nerve, circulatory or kidney problems.*
17. Ears: Have you had: Any condition, disorder or abnormality of the ears including hearing loss, balance problems, tinnitus or infection of the inner ear (such as labyrinthitis)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
18. Eyes Have you had: Blurred or double vision, or any condition, disorder or abnormality of the eyes including glaucoma or cataract? (Sight problems corrected by glasses or contact lens can be ignored).	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
19. Fatigue: Have you had: Chronic fatigue syndrome (CFS), debility or ME?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
20. Head : Have you had: Blackouts, fainting, frequent headaches, migraines, dizziness or vertigo?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
21. Heart: Have you had: Any disease, condition, abnormality or disorder of the heart including heart attack, angina, heart valve disorder, irregular heartbeat, palpitations or heart enlargement?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
22. Hernia: Have you had: A hernia?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Where and the type/site (e.g. left side groin). 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
23. Kidneys and Bladder Have you had: Any disease, condition, disorder or abnormality of the kidney, bladder or urinary tract including blood or protein in the urine and urinary tract infections?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
24. Liver Have you had: Any disease, condition, disorder or abnormality of the liver including hepatitis?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
25. Nervous System (i) Have you had any: a) Disease of the central nervous system including multiple sclerosis (MS), optic neuritis or paralysis?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
b) Numbness, change in skin sensation, muscle weakness or paralysis, tremor or difficulty with upper and/or lower limb co-ordination or walking?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
c) Epilepsy or fits?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when.* *4. Time off work and when.*
26. Nervous System (ii) Do you have: Parkinson's disease, cerebral palsy, Alzheimer's disease or dementia?	
Currently Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when.* *4. Time off work and when.*
27. Lung Disease Have you had: Sarcoidosis, tuberculosis, emphysema or chronic obstructive pulmonary disease?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when.* *4. Time off work and when.*
28. Non Cancerous Conditions Have you had: An internal or external lump, benign tumour, cyst, polyp or growth?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Which condition 2. Dates and durations. 3. Tests carried out, results and when.* *4. Treatment and dates. 5. Time off work and when.*
29. Nose, Throat and Breathing Have you had: Asthma, hayfever, bronchitis, chest infection, nose or sinus problem(s), condition(s) or abnormality(ies)?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when.* *4. Time off work and when.*
30. Sexually Transmitted Disease(s) Have you: Tested positive for HIV, Hepatitis B or C or a sexually transmitted disease or infection, or are you awaiting the result of such a test?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when.* *4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
31. Skin Have you had: Any disease, condition, abnormality or disorder of the skin including eczema, dermatitis, psoriasis or a mole or freckle which has bled, become painful or changed appearance?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
32. Stomach Have you had: Any disease, condition, abnormality or disorder of the digestive system, pancreas, gall bladder, indigestion/heartburn or stomach ulcer?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
33. Thyroid Have you had: Any disease, condition, abnormality or disorder of the thyroid including abnormal thyroid readings?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and dates. 4. Time off work and when. 5. Whether blood results now normal and if so from when.*
34. Urine Have you had: Sugar, protein or blood in your urine or ever been told your urine was not normal?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Which condition. 2. Dates and durations. 3. Treatment and dates. 4. Time off work and when. 5. Whether urine results now normal and if so from when.*
35. Female only Have you had: Painful or heavy periods, abnormal bleeding or any gynaecological (including abnormal cervical smear) for which you have sought advice or been given treatment or investigation or in the case of cervical smear been requested to attend for other than the routine 3 or 5 yearly smears?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Please tick all which apply *(unless Never is selected please ensure you answer for each time period listed below).*	**If answered 'yes' in this section please provide the information asked for** *(please use the additional notes section on page 18 if necessary)*
36. Male only Have you had: Any disease, condition, abnormality or disorder of the male reproductive system, a testicular disorder, prostate disorder or abnormalities including an abnormal PSA test?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*
37. Miscellaneous a) In the last 5 years have you had any medical attention with a doctor or other medical practitioner or at a hospital or required any investigation, scan or test including blood tests which you haven't already mentioned?	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐	*1. Symptoms. 2. Tests carried out. 3. Diagnosis. 4. Duration of problem. 5. Treatment and dates. 6. Time off work and when.*
b) Have you any expectation of seeking medical advice or treatment in the near future or have you been advised to have any medical investigation, test or scan or are you awaiting any results?	
Currently Yes ☐ No ☐	*1. Reason. 2. Symptoms. 3. Nature of test / advice to be sought or already sought. 4. Who consulted / to be consulted. 5. Dates.*
c) Do you have any medical condition(s) or injury(ies) which you haven't already mentioned for which you are taking tablets, medicines, prescribed drugs or any other treatment? For example physiotherapy or alternative therapies (contraceptives and cold/flu remedies can be ignored).	
Never ☐ Currently Yes ☐ No ☐ In the last 5 years Yes ☐ No ☐ More than 5 years ago Yes ☐ No ☐	*1. Name of condition. 2. Dates and durations. 3. Treatment and when. 4. Time off work and when.*

Your family

Have any of your natural parents, brothers or sisters suffered from any of the following before the age of 65?

Condition		Whether you have been advised to have tests as a result of your relatives illness and if so the date, results and whether further tests are due or recommended.
Alzheimer's Disease		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Cancer – please state type below		
Yes ☐ No ☐	Type ______ Age at onset ______ Relative ______	Yes ☐ No ☐
Diabetes		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Heart Disease (including heart attack, angina, bypass, heart enlargement, cardiomyopathy) – please state which type below		
Yes ☐ No ☐	Type ______ Age at onset ______ Relative ______	Yes ☐ No ☐
Huntington's Disease		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Motor Neurone Disease		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Multiple Sclerosis		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Parkinson's Disease		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Polycystic Kidney Disease		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐
Stroke		
Yes ☐ No ☐	Age at onset ______ Relative ______	Yes ☐ No ☐

G.Declarations and consents

Access to Medical Reports Act 1988

- I have read the explanation of my rights under the Access to Medical Reports Act 1988 (page 19) and consent to Cirencester Friendly Society Limited being provided with my medical information, including copies of my medical records, from any medical practitioner who has attended to me concerning anything which affects my physical or mental health or condition.
- I understand that Cirencester Friendly may ask for information from my Medical Practitioner as part of their random disclosure verification process to verify I have given accurate and complete information to Cirencester Friendly. My instruction above applies to those random requests as well and I understand that I will be notified in writing if my application is selected for that check.

  If you wish to see the medical report before it is returned to us. Please tick here ☐

Data Protection Act 1998

- I have read the explanation of the Data Protection Act 1998 (page 19) and I consent to the Society being provided with information from other insurers or third parties concerning my application including, but not limited to, information concerning my physical and/or mental health, previous or concurrent applications for life or health insurance and any relevant financial information.
- I authorise the release of confidential information, including but not limited to, information concerning my physical and/or mental health or condition obtained by the Society, to any doctors or specialists appointed by the Society in relation to the application and to any third party who requires such information for lawful purposes.
- If applicable, I understand a specially trained interviewer will contact me with regards to further medical information for my application for My Earnings Insurance and I consent to this process.
- I consent to medical information being obtained by Cirencester Friendly from my Medical Practitioner under the random disclosure verification process if my application is selected for that check.

Contract Agreement

- I have read and understood the important information on the front page of this application form.
- I have read over the replies to all of the questions in this form and I accept full responsibility for the accuracy of the answers and statements given, even if they were recorded on my behalf and confirm that they are true and complete to the best of my knowledge and belief and I have disclosed all information material to my application. I consent to the Society undertaking any other enquiries they consider necessary concerning this application.
- I understand that the medical information from my Medical Practitioner under the random disclosure verification check (if this application is selected for that check) may be received after the start of the contract. I also understand that if I have not accurately and completely disclosed Cirencester Friendly shall advise me in writing of any changes to the contract and reserves the right to cancel the contract and end membership.
- I understand that the Memorandum and Rules along with the Schedule 3 to the Rules (available from www.cirencester-friendly.co.uk) constitute the contract between me and the Society and it is important for me to read these within 30 days of receipt. *(If there are any terms that you do not understand or do not wish to agree to please discuss it with us or your Financial Adviser before signing. Only sign this application if you wish to be bound by the terms and conditions).*
- I shall advise the Society in writing of any changes in my health and other circumstances (including financial) which happen before the contract commences.
- I hereby apply for Membership of the Society and agree to abide by the Society's Rules, present and future. I further agree that if I have made any incorrect statement in this, my application, the Rules of the Society will be strictly applied.

Signature of Applicant ____________________ Date ☐☐ / ☐☐ / ☐☐☐☐

Print Full Name ____________________

(please use block capitals)

Please Note

The Applicant should not sign the above declaration unless the Application Form has been completed and checked by them for accuracy.

H. Additional information

Question No.

Important information

for all applicants which should be read carefully

Data Protection Act 1998

- For the purpose of the Data Protection Act 1998 the Data Controller in relation to the information you supply is the Cirencester Friendly Society Limited. Any information about you will be put on our database and held in accordance with the Data Protection Act 1998.
- It will be used for the purposes of processing this application and administering your membership.
- We may conduct, or have conducted on our behalf, checks with external agents in connection with this application for validation purposes.
- We or our agents may ask you for more information, or carry out further checks and searches and/or share information with third parties when assessing your application, managing your membership or assessing any future claims for fraud prevention and verification.
- We may ask for information from your Medical Practitioner as part of our random disclosure verification process.
- We may share information about you with:-
  - Third parties – including but not limited to Trustees in Bankruptcy, reinsurers, underwriters, financial institutions, credit reference agencies and medical agencies (including UK and abroad) and sub-contractors and agents in order to provide you with the service applied for, for fraud prevention or so that services may be processed on our behalf.
  - Government regulators and the Ombudsman to help resolve a complaint or for audit purposes.
  - Other insurance companies who require the information for lawful purposes.
- If you ask, we will tell you what information we hold about you and provide information in line with the Data Protection Act 1998 (a fee is payable). You should let us know if you think any information we hold about you is inaccurate, so we can correct it.
- On request from you we will forward you a copy of our Subject Access Request (SAR) forms for completion. You will be required to send the completed forms to us enclosing proof of ID and the specified fee. On receipt of completed and signed forms, your request will be processed and a response made within 40 calendar days from the date they are received. All SAR requests will be subject to legal restrictions placed on disclosure. Please direct enquiries relating to your data to The Data Protection Officer, Cirencester Friendly Society Limited, 5 Dyer Street, Cirencester, Glos GL7 2PP.
- To help improve our service and in the interests of security we may monitor and/or record your telephone calls with us.
- **Notice** – Insurers and Friendly Societies pass information on claims concerning income protection insurance, critical illness insurance and waiver of premium benefits to the Income Protection Claims Register, run by the Association of British Insurers.
- The aim is to prevent fraudulent claims. When you make a claim, we may notify the register of that event.

Access to Medical Reports Act 1988

(or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991)

- Before we can apply for a medical report from a Medical Practitioner who has cared for you, we need your consent by signing the Declarations and Consents. Therefore please read this section before you sign the Declaration as it sets out your rights under the Access to Medical Reports Act 1988 (or 1991 Order) and the procedure for dealing with reports.
- You do not have to give your consent but, if you do not, we may be unable to proceed with your application. If you do consent, you can also say whether you wish to see the report before it is sent to the Society.
- If you tell us you wish to see the report (we will tell you at the same time as we write to the Medical Practitioner and we will tell him/her you wish to see the report), you will then have 21 days to contact him/her about arrangements for you to see the report.
- If you tell us you do not wish to see the report, we do not have to notify you if we apply for one.
- Whether or not you tell us you wish to see the report before it is sent to us, the medical practitioner must let you see a copy for up to 6 months after it is supplied to us, if you ask the medical practitioner.
- If you ask the Medical Practitioner for a copy of the report, he/she can charge you a reasonable fee to cover his/her costs.
- If you have seen a report before it is sent to us, the medical practitioner cannot submit it until he/she has your consent.
- You can write to the Medical Practitioner, asking him/her to amend any part of the report which you consider to be incorrect or misleading and have attached to the report a statement of your views on any part where you and the medical practitioner are not in agreement and which he/she is not prepared to alter.
- The medical practitioner is not obliged to let you see any part of the report if, in his/her opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the medical practitioner's intentions towards you, or if 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 Medical Practitioner must notify you and you will be limited to seeing any remaining part of the report.
- If it is the whole report which is affected, the Medical Practitioner must not send it to us unless you give your consent.

Instruction to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

Cirencester Friendly Society Limited
5 Dyer Street
Cirencester
Gloucestershire
GL7 2PP

Service user number

9	3	0	3	7	9

Name(s) of account holder(s)

Reference

Bank/Building Society account number

Branch sort code

Instruction to your bank or building society
Please pay (Cirencester Friendly Society Limited) 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 (Cirencester Friendly Society Limited) and, if so, details will be passed electronically to my bank/building society.

Name and full postal address of your bank or building society

To: The Manager Bank/building society

Address

Postcode

Signature(s)

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit Cirencester Friendly Society Limited will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Cirencester Friendly Society Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit by Cirencester Friendly Society Limited or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.
  – If you receive a refund you are not entitled to, you must pay it back when Cirencester Friendly Society Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

Notes to help you to complete your application form

Section C

Note 1: Any regular trade, profession, vocation, employment or any other work or activity declared to the Society which serves, or is intended to serve, as a source of earnings.

Note 2: A Fixed Term Contract is a contract of employment which is for a set period e.g. 2 years. At the end of the fixed term you will be treated as being unemployed unless your contract is renewed. Please note that if you make a claim and are working under a Fixed Term Contract you will only be covered and receive benefit for the duration of that contract unless you can prove that your contract would have continued had it not been for your illness or injury.

Note 3: You will be required to provide evidence of your earnings for the 12 months prior to your illness or injury when you make a claim.

- For Employed people you will be required to provide your P60, P11D (where appropriate) and printed payslips.
- For Self Employed or those in Partnership we will require your most recent business accounts and your latest HMRC tax calculation/computation/return.
- For Company Directors we will require the company's most recent business accounts and your latest HMRC tax calculation/computation/return along with your P60, P11D (where appropriate) and printed payslips.

Please note you may also be required to provide other earnings evidence in the event of a claim.

Section D

Note 4: It is possible to arrange payment of Health Benefit with two deferred periods.

- The amount of Health Benefit for both deferred periods (or day 1 and another period) must not exceed the total Health Benefit available under your contract.
- The minimum health benefit for either deferred period must be £4,160 per annum.

Your Financial Adviser will assist with these options.

The deferred period relates to the time between the onset of your illness or injury and the date you require the payment of Health Benefit to commence (for example, if your employer continues to pay your salary for the initial four weeks of your illness then a four week deferred period may be suitable for you). MEI offers a range of deferred periods to suit your circumstances a choice of deferred period cover of 4, 8, 13, 26 and 52 weeks are available. Cover from day 1 is also available (you must be off work for more than three consecutive days to qualify).

Note 5: MEI offers a choice of premiums. There is no difference in the cover available between either. You must decide between:

A premium where the monthly amount you pay increases every year during the month of your birthday. This means that your premiums will be lower in the earlier years of the contract. Your Payment Plan will explain how much you will pay throughout the term of your contract so there will be no surprises in future years. We call this an Annual Escalating Premium.

OR

A premium where your monthly payment will remain the same throughout the term of your contract. We call this a Level Premium.

Your Financial Adviser will help with this decision.

Note 6: If you have selected deferred period or split period cover (not day 1) then you may also wish to add Severe Injury Cover ("SIC"). This means that in the event of not being able to work and earn a living as a result of a specified injury you will qualify for Injury Benefit provided you meet the claims criteria. The specific injuries covered under SIC are listed in the Premium Tables.

Note 7: In order to protect your Health Benefit against future inflation MEI offers the option to link the contract to Average Weekly Earnings (AWE). This means that your premium and any benefits to which you may be entitled will be reviewed annually to allow for the effects of inflation.

If Indexation is not arranged at the commencement of the contract then it can be arranged at any time during the term of the contract subject to underwriting.

Note 8: The Occupational Retirement Age is the age stipulated by the Society as the retirement age for your particular occupation. Stipulated retirement ages can be found in the "My Earnings Insurance Occupational Retirement Ages Booklet" (the ORA).

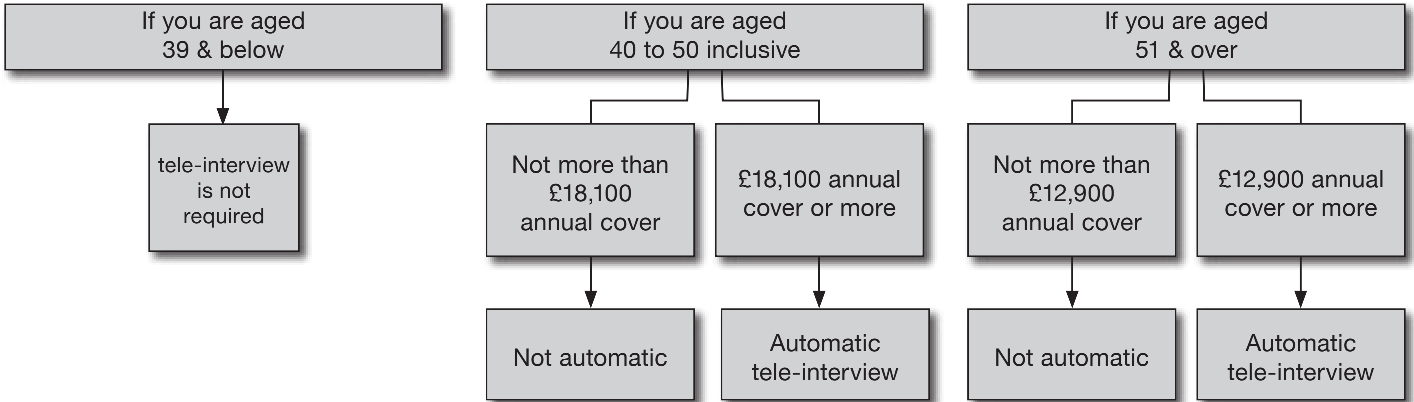
Section F

Note 9: A telephone interview is one of the methods we use to capture your medical information. We will schedule a telephone call with you and a trained nurse who will ask you questions about your medical history.

Note 10:

So that we can process your application without delay and offer you terms we need to gather medical information. We can do this a number of ways. You can **either** complete Section F of this form or give the information to a registered nurse over the telephone (a tele-interview).

The following diagram will help to establish if a tele-interview will **normally apply**.



If a tele-interview applies you need not complete the medical questions in Section F.

If you **do not** want to have a tele-interview, or one is not automatically required as above then you can simply complete Section F of this form.

Note 11: A Hazardous Activity is any recreational activity which may increase your risk of incurring an injury which may leave you unable to work and earn a living. Although we do not automatically increase premiums or impose an exclusion for those who participate in these activities we do ask you to provide information on any Hazardous Activity that you undertake.

How to submit an application form

Scan & email: newbusiness@cirencester-friendly.co.uk

Post: Cirencester Friendly, 5 Dyer Street, Cirencester, Glos. GL7 2PP

For Financial Adviser use only

Please complete the following information for processing purposes.

Adviser's Name and Correspondence Address ______________________

FCA Firm Ref. No. ______________________ FCA Individual Ref. No. *(If applicable)* ______________________

Society Ref. Code *(If known)* **B** ______________________

Tel ______________________ Fax ______________________

Email ______________________
(This will be used for contacting you about the application)

Network Name *(If applicable)* ______________________

Introductory Commission option: (full details on www.cirencester-friendly.co.uk):

☐ Indemnity ☐ Non Indemnity

Confirmation of Verification of Identity and checking of HMT Financial Sanctions list

I/we confirm that:

- the information in this section was obtained by me/us in relation to the customer;
- the evidence I/we have obtained to verify the identity of the customer meets or exceeds the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG;
- the customers' name does not appear on HM Treasury UK Consolidated Financial Sanctions list.
- Where a third party is involved e.g. the customer is not the bank account holder and therefore not the payer of the premiums, or where bank accounts require more than one person to authorise debits e.g. business accounts or joint bank accounts, the identity of the person or persons must be verified and confirmation provided.

Full Name of Financial Adviser ______________________

Position ______________________

Financial Adviser Signature ______________________ Date ☐☐ / ☐☐ / ☐☐☐☐

Cirencester Friendly Society Limited
5 Dyer Street
Cirencester
Glos.
GL7 2PP

Tel: 01285 652492/653073
Fax: 01285 641246
Email: info@cirencester-friendly.co.uk
Web: www.cirencester-friendly.co.uk

Cirencester Friendly is a trading name of Cirencester Friendly Society Limited.
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Cirencester Friendly Society Limited is Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority under the registration number 109987.

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V3A (MAR 2017)