

MY EARNINGS PROTECTED DATA CAPTURE FORM



FOR ADVISER USE ONLY

DATA CAPTURE FORM FOR ONLINE SUBMISSION

This Data Capture Form cannot be used to apply for a contract – it is designed to capture the basic responses from your client, which will need to be submitted using Cirencester Friendly's Adviser portal.

To apply please visit www.cirencester-friendly.co.uk and log into our Adviser portal.

To apply for a My Earnings Protected contract your client must:

- Live in the UK and their earnings are taxable in the UK
- Be registered with a UK Doctor, who can supply up to date three years medical history
- Be employed or self-employed earning at least £6,400 per year
- Be 18 or over and haven't yet had their 55th birthday (their contract must commence before they turn 55)

My Earnings Protected is sold on an individual basis.

APPLYING FOR MY EARNINGS PROTECTED



We have worked on building our own unique underwriting engine which, alongside our expert Underwriting Team, aims to make your client's online application process as smooth as possible.

Our online application process is designed to gather information we require through dynamic questioning, in order to provide as many applicants as possible with an instant decision. If the answer is given to the correct question, the chance of an instant decision will be increased. Please note, any information that is supplied in the miscellaneous section will be automatically referred for manual underwriting.

The quickest and most effective way to apply for My Earnings Protected is to login at **www.cirencester-friendly.co.uk** with your client, and follow the links to our online application form.

IMPORTANT NOTES

Automatic Medical Evidence

Depending on a clients age and level of benefit, we may require further medical evidence. Please see table below.

Age	Level of cover at which we need automatic evidence
39 and below	No automatic evidence
40-50	£3,001 (and above) per calendar month
51+	£2,001 (and above) per calendar month

Conditions we can't cover

Unfortunately, we can't offer cover to everyone who applies. Following is a list of medical conditions which would lead to us automatically declining an application.

- Multiple sclerosis (MS), Motor neurone disease (MND), Parkinson's disease, Huntington's disease or dementia (including Alzheimer's disease)

- Bipolar disorder, manic depression, schizophrenia, borderline personality disorder
- Polycystic kidney disease (PKD)
- Cardiomyopathy
- Cirrhosis
- AIDs (we are able to consider some applications with HIV, please refer to Our Guide to Underwriting)
- Systemic lupus erythematosus (SLE)
- A major organ transplant (as a recipient)
- Cystic fibrosis
- Ehlers Danlos
- Sickle Cell anaemia (if trait only, refer to our underwriters)

Current symptoms of the following conditions:

- Long covid
- Chronic Fatigue Syndrome (CFS)
- Fibromyalgia

Genetic testing

You do not need to tell us about any predictive genetic test. However, you must advise us if you are experiencing symptoms of or are having treatment for a medical condition, including any genetically inherited conditions, including the result of any diagnostic tests. You must also advise us of any family history of a condition that is covered in the relevant section of the application form.

You can advise us of a negative genetic test result at your discretion, as this may lead to the Society offering more favourable terms.

A copy of the Code on Genetic Testing and Insurance is available from us on request or from the ABI website <http://www.abi.org.uk> or you can view it on Gov website <https://www.gov.uk/government/publications/code-on-genetic-testing-and-insurance>.

QUOTE DETAILS



We require accurate and complete health information to be provided at application.

Title

First name(s)

Surname

Date of birth (You must be 18 or over and haven't yet had your 55th birthday) / /

Gender at birth

Nationality

Address

Postcode

Telephone Number Email

Occupation

Employment type Employed Self Employed Company Director

Hours worked per week

What is your personal taxable income? £

(If you are employed, please state your personal taxable income for the current tax year. If you are self-employed, please state your projected earnings for the current tax year)

PREMIUM TYPE

(A Guaranteed Level premium will remain the same throughout the term of your contract*, and a Guaranteed Annual Escalating premium will increase annually**)

Level premium Annual Escalating premium

*Subject to indexation and contract changes.

**Subject to age band increases, indexation and contract changes.

Retirement Age

(You can select any contract end date between age 55 and 70)

Would you like the benefit to be index-linked? Yes No

DEFERRED PERIOD

Please confirm your chosen deferred period from the options below. If you require a split deferred period, please select a second deferred period.

Deferred Period 1

1 Week 4 Weeks 8 Weeks 13 Weeks 26 Weeks 52 Weeks

Deferred Period 2

1 Week 4 Weeks 8 Weeks 13 Weeks 26 Weeks 52 Weeks

Amount of Benefit

Please confirm the amount of monthly benefit you require. If you have chosen a split deferred period, please confirm the benefit amount for each period.

Deferred Period 1 Deferred Period 2
£ £

Would you like to add Severe Injury Cover?

Yes No

(If 'yes' please indicate which deferred period you would like to add this to)

1st deferred period 2nd deferred period Both

Which claim period would you like to choose? Long-Term Short-Term (2 years)

OCCUPATION

Other than statutory sick pay (SSP), are you entitled to any earnings or company sick pay if you are off work due to illness or injury in your main job or occupation?

Yes No

(If 'Yes' please provide details e.g., how much, how often and for how long)

Do you have any other job, occupation, or activity (sports & hobbies included) from which you receive additional income?

Yes No

(If 'Yes' please provide details e.g., what job, occupation or activity, time spent per week/month and income/earnings)

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

Yes No

(If 'Yes' please provide details e.g. the illness or injury, which duties have been amended, how many hours you've been reduced to. Please note that we're unable to offer cover if you're not currently working)

HEIGHT/WEIGHT

What is your height? (Without shoes)

feet inches or meters

What is your weight?

stones pounds or kgs

If you're uncertain of your current weight, please ensure you weigh yourself before answering. If you're currently pregnant, please tell us your weight immediately before your pregnancy.

TOBACCO OR NICOTINE USAGE

Selectable options as below:

Regular, occasional or social use	<input type="checkbox"/>	Completely stopped between 3 and 5 years ago	<input type="checkbox"/>
Completely stopped within 12 months	<input type="checkbox"/>	Completely stopped more than 5 years ago	<input type="checkbox"/>
Completely stopped between 1 and 3 years ago	<input type="checkbox"/>	Never used	<input type="checkbox"/>

CIGARETTES & OTHER TOBACCO PRODUCTS

Only answer the following questions if you are a regular, occasional social smoker or if you have smoked within the last 12 months

Cigarettes (daily)	<input type="text"/>
Small cigars (daily)	<input type="text"/>
Large cigars (daily)	<input type="text"/>
Pipe tobacco (bowls per day)	<input type="text"/>
Rolling tobacco (grams per week)	<input type="text"/>

In the last 12 months, have you used e-cigarettes/vapes (regardless of whether they contain nicotine) or any other nicotine replacement product (e.g., patches, gum, spray)? Yes No

ALCOHOL & DRUG USE

What is your typical weekly consumption of:

Higher-strength Lager, Beer or Cider (pints)	<input type="text"/>
Normal Lager, Beer or Cider (pints)	<input type="text"/>
Wine (small glass, 125ml)	<input type="text"/>
Wine (medium or standard glass, 175ml)	<input type="text"/>
Wine (large glass, 250ml)	<input type="text"/>
Spirits (single measures, 25ml)	<input type="text"/>
Alcopops (275ml bottles)	<input type="text"/>

At any time 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/substance abuse? Yes No

(If 'Yes' please provide details e.g., what advice/treatment and when)

SPORTS & HOBBIES

Do you currently, or have you any intention of engaging in a Hazardous Activity? Yes No

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 Activities that you undertake. Examples of Hazardous Activities include, but are not limited to: Motor sport, Rugby, Horse riding, Aviation, Diving or Mountaineering. For the avoidance of doubt, if you are unsure whether any recreational activity that you participate in would be classed as a Hazardous Activity, please tell us about it. **Please note if your client participates in any form of motor sport, all contracts will have a standard exclusion for motor sport.**

How many Hazardous Activities do you currently, or have you any intention, of engaging in? 1 2 3 or more

Which hazardous activity(ies) does this relate to?

Have you suffered more than one injury that required medical attention, hospitalisation, treatment or time off work whilst participating in this Hazardous Activity in the last three years? Yes No

(Please note that we would group certain hobbies together for the purpose of accidents or injuries, for example road cycling and mountain biking)

Tell us about the specifics of any injury suffered above in the medical section below, making it clear which hazardous activity each injury relates to.

MEDICAL HISTORY

If you answer 'Yes' to any of the health questions, you will be prompted to answer further questions about that medical condition near the back of this form.

Have you ever been diagnosed, suffered from or had any of the following?

- Arthritis (including gout) Yes No
- Surgery to your neck, back or spine or Ankylosing Spondylitis Yes No
- Fracture resulting in placement of metalwork (regardless of whether any metalwork is still in place today) Yes No
- Joint replacement Yes No
- Joint dislocation or ACL rupture/tear injury Yes No
- Fibromyalgia Yes No
- Chronic fatigue syndrome (CFS), debility or Myalgic Encephalomyelitis (ME) Yes No
- Any eating disorder, addiction or other mental health condition that has required inpatient treatment or referral to a psychiatrist or psychologist Yes No
- Cancer or tumour Yes No
- Any disease, condition, abnormality or disorder of the heart (e.g., angina, heart attack, irregular heartbeat or palpitations) Yes No
- Any disease, condition, abnormality or disorder of the blood vessels (arteries or veins) that carry blood to and from the brain (e.g., stroke or brain haemorrhage) Yes No
- Any disease, condition or disorder of the brain and spinal cord (central nervous system) including optic neuritis (e.g., encephalitis or paralysis) Yes No
- Any disease, condition or disorder of the nerves that lie outside of the brain and spinal cord (e.g., trigeminal neuralgia, tremor or difficulty with upper and/or lower limb co-ordination or walking) Yes No
- Ulcerative colitis or Crohn's disease Yes No
- Epilepsy or seizure disorders Yes No

- Hepatitis Yes No
- Sarcoidosis Yes No
- HIV Yes No

Have you been diagnosed, suffered from, had treatment for or had any problems relating to any of the following within the last 5 years?

You do not have to repeat anything that you have already mentioned.

- A broken bone or fracture Yes No
- Any disease, condition or disorder of the neck or back Yes No
- Any disease, condition or disorder of any joint, ligament, tendon, cartilage, muscle or any repetitive strain injury Yes No
- Any disease, condition or disorder of the bones (e.g., osteopenia or osteoporosis) Yes No
- Any condition, disorder or abnormality of the blood (e.g., anaemia or sepsis) Yes No
- High or low blood pressure Yes No
- Raised cholesterol Yes No
- Any disease, condition or abnormality of the arteries or veins (e.g., deep vein thrombosis (DVT), varicose veins or raynaud's disease) Yes No
- Any disease, condition, abnormality or disorder of liver, gall bladder, pancreas Yes No
- Hernia Yes No
- Any disease, condition or abnormality of the kidney, bladder, urinary tract (e.g., blood in the urine or urinary tract infections) Yes No
- Any disease, condition, abnormality or disorder of the bowel or digestive system (e.g., coeliac disease or irritable bowel syndrome) Yes No
- Diabetes Yes No
- Any disease, condition or abnormality of the thyroid or parathyroid glands Yes No
- Depression, anxiety, stress, low mood, panic attacks, bereavement reaction, anger management, fatigue or insomnia Yes No
- Any condition, disorder or abnormality of the eyes or ears Yes No
- Any disease, condition or abnormality of the nose, sinuses, throat, airways or lungs (e.g. Coronavirus (Covid-19), asthma, sinusitis, sleep apnoea, tuberculosis) Yes No
- Headaches, migraines, fainting, blackouts, dizziness or vertigo Yes No
- Any disease, condition, abnormality or disorder of the male reproductive system Yes No
- Painful or heavy periods, abnormal bleeding or any gynaecological condition Yes No
- Tested positive for a sexually transmitted disease or infection, or awaiting the results of such a test Yes No
- An internal or external lump, benign tumour, cyst, polyp or other growth Yes No
- Any disease, condition, abnormality or disorder of the skin Yes No

MISCELLANEOUS

Apart from anything that you have already told us about:

If you answer 'Yes' to any of the questions below, please provide more details on the additional notes section on page 12.

Please note that if this section is completed, the application will be automatically referred for manual underwriting. Please check if any answers can be provided in the main question set.

- In the last five 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? Yes No
- Are you considering 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? (we don't need to know about any routine appts such as cervical smear, mammogram etc) Yes No
- Do you have any other medical condition or injury for which you are taking tablets, medicines, prescribed drugs or any other treatment (e.g., physiotherapy or chiropractor)? Yes No
- Other than for anything you have already mentioned, have you had time off work in the last 2 years due to sickness, illness or injury? Yes No
- Is there anything else concerning your occupation or personal medical history that you would like us to take into account in the assessment of your application? Yes No

FAMILY HISTORY

Have any of your birth/biological parents, brothers or sisters been diagnosed with, or died from any of the following conditions before the age of 65?

- Alzheimer's Disease Yes No
- Cancer Yes No
- Diabetes Yes No
- Heart Disease (including heart attack, angina & bypass surgery) Yes No
- Stroke (including transient ischaemic attack (TIA) or "mini stroke") Yes No
- Cardiomyopathy Yes No
- Huntington's Disease Yes No
- Motor Neurone Disease (MND) Yes No
- Multiple Sclerosis (MS) Yes No
- Parkinson's Disease Yes No
- Muscular dystrophy Yes No
- Polycystic Kidney Disease (PKD) Yes No
- Haemochromatosis Yes No
- Any other hereditary disease or disorder Yes No

FURTHER MEDICAL INFORMATION



CONDITION 1

Name of condition

Date of first symptoms and diagnosis (if different)

Current and past treatment or medication (including dosage and frequency)

Results and dates of investigations including, blood tests, ECG's, x-rays, scans, blood pressure & cholesterol readings

Describe your symptoms, their severity, (e.g., mild, moderate, severe) and frequency if ongoing

Have you been admitted to hospital with this condition? If Yes, please provide details and dates

Have you had any complications because/as a result of this condition? If Yes, please provide details

Does your condition limit your ability to work or carry out your normal daily activities? If Yes, please provide full details

Are you still under review and if so how frequently?

Have you had time off work because of this? If Yes, please provide details and dates

Have you made a full recovery? If Yes, please advise when you last had symptoms of this condition

CONDITION 2

Name of condition

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Date of first symptoms and diagnosis (if different)

Current and past treatment or medication (including dosage and frequency)

Results and dates of investigations including, blood tests, ECG's, x-rays, scans, blood pressure & cholesterol readings

Describe your symptoms, their severity, (e.g., mild, moderate, severe) and frequency if ongoing

Have you been admitted to hospital with this condition? If Yes, please provide details and dates

Have you had any complications because/as a result of this condition? If Yes, please provide details

Does your condition limit your ability to work or carry out your normal daily activities? If Yes, please provide full details

Are you still under review and if so how frequently?

Have you had time off work because of this? If Yes, please provide details and dates

Have you made a full recovery? If Yes, please advise when you last had symptoms of this condition

CONDITION 3

Name of condition

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Date of first symptoms and diagnosis (if different)

Current and past treatment or medication (including dosage and frequency)

Results and dates of investigations including, blood tests, ECG's, x-rays, scans, blood pressure & cholesterol readings

Describe your symptoms, their severity, (e.g., mild, moderate, severe) and frequency if ongoing

Have you been admitted to hospital with this condition? If Yes, please provide details and dates

Have you had any complications because/as a result of this condition? If Yes, please provide details

Does your condition limit your ability to work or carry out your normal daily activities? If Yes, please provide full details

Are you still under review and if so how frequently?

Have you had time off work because of this? If Yes, please provide details and dates

Have you made a full recovery? If Yes, please advise when you last had symptoms of this condition

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

Cirencester Friendly Society Limited Mutuality House The Mallards South Cerney Cirencester Glos. GL7 5TQ
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Name(s) of account holder(s)

Bank/Building Society account number

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Branch sort code

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Name and full postal address of your Bank or Building Society

To: The Manager	Bank/Building Society
Address	
Postcode	

INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

Service user number

9	3	0	3	7	9
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Reference

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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.

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.



CONTACT US

Financial Advisers:

Adviser Services Team: 0800 587 5098
adviserservices@cirencester-friendly.co.uk

Underwriting:

Underwriting Team: 0800 587 5098
underwriting@cirencester-friendly.co.uk

Members:

Member Services Team: 0800 587 5098
memberservices@cirencester-friendly.co.uk

Opening times:

Monday to Friday 8:45am – 5pm

Telephone hours: 9am - 5pm, Monday, Tuesday, Wednesday and Friday, 10am to 5pm Thursday (excluding Public Holidays).

Calls may be recorded and monitored.

Postal address:

Cirencester Friendly Society,

Mutuality House, The Mallards, South Cerney, Cirencester, Gloucestershire, GL7 5TQ

Website:

www.cirencester-friendly.co.uk



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