Synergy Protect

Alteration Form

Level Term Assurance & Mortgage Protection

Your Protection Plan

Including:

Life Insurance
Critical Illness
Insurance Income
Protection Insurance

CONTENTS

CUSTOMER CHECKLIST

Please tick the boxes below to confirm the following:

	Tick to confirm
1. Each insured and plan holder if different has read the important customer notes on page 3.	☐
2. Each insured and plan holder if different has signed and dated the Application Form on page 19.	☐
IMPORTANT NOTE - If you do not complete this application form yourself, you must check that all of the answers given to all of the questions are accurate and complete before signing the declaration on page 19.	
3. Each bank account holder has signed and dated the direct debit instruction on page 23.	☐
IMPORTANT NOTE - If two people are applying for cover using this form, we will require two separate direct debits even if the premiums will be collected from the same bank account.	
4. Any additional sheets attached to this application are signed and dated by the relevant Insured(s).	☐

GUIDANCE NOTES ON COMPLETING THIS FORM

1. Throughout this form the following definitions apply:

- The insured is the person who will be covered by the insurances in this plan
- The plan holder is the person who will own the plan if different to the insured.

2. Where the insured and the plan holder is the same person, he or she should complete all sections of this Application Form apart from those applicable to the Financial Adviser (see point 5 below).

If the insured and plan holder are different, the insured should complete the following sections:

- The insured's details on page 4;
- The data protection details on page 5;
- The insured's personal details on page 6;
- The insured's occupation details on 7;
- The insured's health questions on pages 11 to 16;
- The insured's doctors details on page 16; and
- The access to medical reports consent form on page 19,

and the plan holder all other sections.

3. The insured and plan holder (if different), must sign the declaration on page 19.

4. The direct debit on page 23 should be completed by the person whose bank account will be used to collect the premiums from. Please note:

a. All bank account holders must sign the direct debit.
b. If two applications are being made in this application form a separate direct debit is required for each plan.

5. The following sections should be completed by the Financial Adviser:

- Confirmation of verification of identity forms on pages 20 and 21 (one form per plan holder);
- Adviser checklist on page 22;
- Financial Adviser details on page 22.

Synergy Protect

IMPORTANT CUSTOMER NOTES (Please read these notes carefully before completing this Application Form).

1) Use blue or black ink and BLOCK LETTERS throughout. If you make a mistake please cross it out, put in the correct word or words and initial next to the correction - do not use correction fluid.

2) Please take reasonable care to answer all the questions honestly and to the best of your knowledge. If you don't a claim may be rejected or not fully paid or your policy may be cancelled. Please answer all the questions as failure to do so will mean that your application may be delayed as we will have to contact you for the missing answers. Please do not assume that we will contact or obtain a report from your doctor.

3) All of the questions in this application form will be considered by The Prudential Assurance Company Limited (the 'Insurer') in assessing the acceptability of your application. The Insurance Cover will be provided by The Prudential Assurance Company Limited.

4) Submission of a completed Application Form does not imply commencement of the protection risk. A letter of acceptance from Synergy Financial Products Limited on behalf of the insurer will indicate the insurance risk is acceptable.

5) If the plan holder is not the insured you must have sufficient insurable interest to be able to apply for the plan on this basis. If you are in any doubt, please speak to your financial adviser.

6) The plan will not start until we have assessed and accepted your application, and the first premium has been paid. If you have a birthday while your application is being processed, the terms may differ from those originally quoted. In most instances your payments will be as originally quoted but we may offer you revised terms and occasionally we may not be able to offer any terms.

7) You are advised to complete this Application Form yourself. If someone else fills in this form for you (e.g. your financial adviser) it is important that you do not sign the Application Form until you are fully satisfied that the answers given to all the questions are accurate and complete.

8) If you would prefer, you may complete the health questions in private and return them direct to our Chief Medical Officer (at the address on the back of this form). Please indicate on this form if you have done so.

9) It is very important that you tell us if there is a change to any of the following between completion of this Application Form and your Plan cover starting:

   a) The Insured's personal health; b) The Insured's family history; c) The Insured's occupation;
   d) The Insured's participation in any hazardous leisure activities; e) The Insured's travel or residence;
   f) The Insured's lifestyle (smoking/alcohol consumption/etc).

   If you do not, this may result in the non-payment of any claim or your plan being cancelled.

10) If this application, taken together with any other insurance policies you already have, is for life insurance up to a sum of £500,000 or critical illness up to £300,000 you need not disclose any genetic test you may have had. You need not disclose the result of any genetic test undertaken in the context of research. Genetic test results need only be disclosed where the sum exceeds either £500,000 for life insurance or £300,000 for critical illness and their use by insurers has been independently approved. You may, of course, disclose any genetic test result, which is in your favour. If you either have a family history of, are experiencing symptoms of, or are having treatment for, a genetic condition, you must tell us. Further information is available on request, which fully explains this policy and details those genetic tests approved for use by insurers.

11) If we ask the insured to attend a medical examination, we will need to share the Application Form information with another company we have authorised. They will make the arrangements for the examination to take place. We may need to send your Application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered. They may also need these at a later stage for purposes relating to managing the plan. You can get details of general reassurance principles and details of any company we use to assess your application, from our head office (see back page). We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it. We may ask the Insured to contact their doctor if we are waiting for reports which we have asked for.

12) If two people are applying for a Synergy Protect Plan using this Application Form, each will be considered an individual insured and each will effect a Synergy Protect Plan of their own. Both insured's are required to complete a separate direct debit instruction (even if premiums will be collected from the same bank account).

13) You are entitled to ask for a copy of the Plan Terms and Conditions and a copy of your Application Form at any time.

14) Please read the Synergy Protect Terms and Conditions for the full plan details.

15) Your Financial Adviser is acting on your behalf by giving advice and in relation to the way this application is completed.

16) If this application is being submitted to us online by your Financial Adviser this is with your consent and authorisation. If this happens:

- We will provide you with a copy of the 'Customer Guide to Online Applications'
- We will send you a copy of the Application Form confirming details of the information submitted by your adviser
- You must check the Application Form very carefully to ensure it is accurate and complete and return a signed declaration confirming this. However, if it is inaccurate or incomplete (e.g. there were any errors, omissions, or incomplete answers) you must notify us immediately. In such cases we reserve the right to amend any terms offered or decline cover.

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL

THE INSURED'S DETAILS - the person(s) who will be covered by this plan

	First/Single insured	Second insured
Title		
First name(s)		
Surname		
Current address		*Only complete if different to first Insured*
Postcode *The Postcode is essential*		
Tel number Day/Work		
Evening/Home		
Email		
Date of birth	☐☐ – ☐☐ – ☐☐☐☐	☐☐ – ☐☐ – ☐☐☐☐

We will need to see your Birth Certificate, and, if you are a married woman, your Marriage Certificate to authenticate these details before a claim can be paid.

Sex	Male ☐ Female ☐	Male ☐ Female ☐
Marital status		

For example, Single, Married, Civil Partnership, Divorced, Separated, Widowed, Co-Habiting.

Total yearly earnings	£	£

THE PLAN HOLDER'S DETAILS - only complete if different to the Insured's details above

	First/Single plan holder	Second plan holder
Title		
First name(s)		
Surname		
Company name (if applicable)		
Current address		*Only complete if different to first Insured*
Postcode *The Postcode is essential*		
Tel number: Day/Work		
Evening/Home		
Email		
Relationship to the insured: For example, Husband, Wife, Partner, Civil Partner, Co-Habiting, Employer.		

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL

ADVICE

	First/Single insured		Second insured	
Did your financial adviser provide you with advice in relation to this product?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

MORTGAGE DETAILS

	First/Single insured		Second insured	
1. Is the plan being taken out in connection with a mortgage?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

2. If Yes, please confirm the address of property being mortgaged

If possible please complete this section but it is not mandatory. If the address of a new property is not known, then please advise us of it as soon as possible.

		Only complete if different to first Insured
Postcode		

3. If No, what is the reason for the insurance application, i.e. personal/family protection, key person insurance etc.

IMPORTANT NOTE:

All correspondence will be sent to the plan holder's address shown on page 4 until your plan commences and direct debit collections begin, and thereafter to the address of the property being mortgaged as indicated in (2) above.

DATA PROTECTION ACT

Synergy Financial Products Limited is a data controller within the meaning of the Data Protection Act 2018. You hereby consent to such use by Synergy Financial Products Limited of the personal information given under this contract as may be reasonably necessary in providing services to you and in updating our customer records. You are entitled to have access to the data we hold about you and you are entitled to have your personal data rectified or erased. Please refer to our privacy policy on our website address below to read more about your rights.

In the interests of proper administration of the plan, Synergy Financial Products Limited, or its representatives acting on its behalf, may contact you.

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL

THE INSURED'S PERSONAL DETAILS

First/Single insured | Second insured

1. Have you in the last 5 years or do you intend to:

(a) Participate in any sport or pastime which involves any additional risk of accident such as motor sports, mountaineering or underwater activities?

☐ Yes ☐ No | ☐ Yes ☐ No

If Yes, please provide details.

If Yes, please provide details.

(b) Travel or reside abroad (apart from holiday visits)?

☐ Yes ☐ No | ☐ Yes ☐ No

If Yes, please provide details. include countries visited, duration of visits, frequencies of visits.

If Yes, please provide details. include countries visited, duration of visits, frequencies of visits.

(c) Fly (except as a fare-paying passenger on an established public service) or take part in aviation-related sports?

☐ Yes ☐ No | ☐ Yes ☐ No

If Yes, please provide details.

If Yes, please provide details.

(d) Do you serve in the Territorial Army or the Volunteer Reserves of the Armed Forces?

☐ Yes ☐ No | ☐ Yes ☐ No

2. Do you have any other Synergy Protect Plans?

☐ Yes ☐ No | ☐ Yes ☐ No

If Yes, please provide the plan number(s).

If Yes, please provide the plan number(s).

3. Do you have or are you currently applying for any critical illness insurance cover with us or any other company? (excluding this application)

☐ Yes ☐ No | ☐ Yes ☐ No

If Yes, please state the total sum assured you are or will be covered for.

£

If Yes, please state the total sum assured you are or will be covered for.

£

4. Have you ever been declined (refused cover), deferred or offered non-standard terms for life cover, critical illness or any incapacity benefit?

☐ Yes ☐ No | ☐ Yes ☐ No

If Yes, please give names of insurance companies.

If Yes, please give names of insurance companies.

5. Is this application to replace an existing Synergy Protect Plan or a plan with another insurer?

Synergy Protect ☐ Yes ☐ No | Other insurer ☐ Yes ☐ No

Synergy Protect ☐ Yes ☐ No | Other insurer ☐ Yes ☐ No

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL

1. What is your employment status?

Employed full time (16 hours or more each week)……..		
Employed part time (less than 16 hours each week)……..		
Self-employed……..		
House person……		
Unemployed……..		
Student……		
Retired……		

2. What is your Occupation?

3. Do you work for any of the following?

HM Forces……	Yes	No	Yes	No
Fishing Industry……...	Yes	No	Yes	No
Oil and Gas Industry (Rig or offshore)……	Yes	No	Yes	No
Sports Professional……	Yes	No	Yes	No
Licensed Trade……	Yes	No	Yes	No
Entertainment……	Yes	No	Yes	No

If none of the above is applicable, please state the type of business / industry in which you work:

4. Does your occupation involve any form of manual or physical activity (including, but not limited to, lifting and carrying or the need to work on your feet for long periods)

Yes ☐ No ☐ Yes ☐ No ☐

If **Yes,** please detail the main manual or physical tasks you do and specify the percentage of your day spent doing this task.

Task	**% of day**	**Task**	**% of day**
Driving		Driving	
Lifting/Carrying		Lifting/Carrying	
Standing		Standing	
Other		Other	

If **other,** please state:

5. Does your occupation involve work at heights over 40ft (12.2 metres)?

Yes ☐ No ☐ Yes ☐ No ☐

If **Yes**, please answer the following questions (delete ft/m as appropriate):

(a) Average height you work at	ft/m	ft/m
(b) Maximum height you work at	ft/m	ft/m
(c) % of time working above 40 feet	%	%

6. Does your occupation involve driving more than 18,000 miles per annum?

Yes ☐ No ☐ Yes ☐ No ☐

7. Does your occupation involve working with any form of machinery or tools?

Yes ☐ No ☐ Yes ☐ No ☐

If **Yes**, please give full details:

Type of machinery or tool	% of the day	Type of machinery or tool	% of the day

8. Does your job involve any of the following:

a. Commercial Underwater Diving…..	Yes	No	Yes	No
b. Being Underground……	Yes	No	Yes	No
c. Handling Explosives……..	Yes	No	Yes	No

THE INSURANCE COVER YOU REQUIRE

Life and Critical Illness Insurance

	First/Single plan holder	Second plan holder
A Life Insurance (including Terminal Illness cover)	£	£
	☐ **Level Cover** OR	☐ **Level Cover** OR
	☐ **Decreasing Cover**	☐ **Decreasing Cover**
B Life Insurance with Critical Illness Insurance	£	£
	☐ **Level Cover** OR	☐ **Level Cover** OR
	☐ **Decreasing Cover**	☐ **Decreasing Cover**
C Critical Illness Insurance (Stand Alone)	£	£
	☐ **Level Cover** OR	☐ **Level Cover** OR
	☐ **Decreasing Cover**	☐ **Decreasing Cover**

IMPORTANT NOTES:

(1) You can only select decreasing cover if your Application is in connection with a mortgage.

(2) If you select decreasing cover, the sum insured will decrease over the plan term selected on page 10, in line with a hypothetical capital and interest mortgage.

Cover Increase Option

	First/Single plan holder		Second plan holder	
Do you require this benefit?	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

IMPORTANT NOTES:

(1) This option is only available to insureds who are accepted on standard terms and are under 40 years of age when cover starts.

(2) The option applies to life insurance (including terminal illness cover), life insurance with critical illness insurance, critical illness insurance (stand alone) and income protection insurance.

(3) This option covers family events (birth or adoption of a child, marriage or entering into a civil partnership) and provided the Plan is taken out in connection with a mortgage, subsequent increases to your mortgage.

Please refer to the Plan Terms and Conditions for full details including any maximums and limitations.

THE INSURANCE COVER YOU REQUIRE

Income Protection Insurance

	First/Single plan holder	Second plan holder

A. Do you want the waiver of premium benefit in the event of incapacity?

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

IMPORTANT NOTE:

If YES, in the event of a claim, the amount payable will match the plan premiums due.

B. Do you want to include a specified amount of income protection benefit in the plan?

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

If Yes, please specify the required amount

£ per month | £ per month

IMPORTANT NOTE:

If YES, in the event of a claim, the total benefit payable (including any waiver of premium benefit) under all income protection policies (from this plan and any others with other providers) will not exceed 55% of your average monthly gross earnings in the 12 months prior to the commencement of incapacity.

Please refer to the Plan Terms and Conditions for full details including any maximums and limitations.

Deferred period required

Weeks			**Weeks**		
☐ **4**	☐ **13**	☐ **26**	☐ **4**	☐ **13**	☐ **26**

This is the earliest period that must elapse from the date of the cause of the claim before any payments can start.

Maximum claim payment period required

2 years	☐	☐	2 years
or			or
Term expiration or to age 65 if earlier	☐	☐	Term expiration or to age 65 if earlier

IMPORTANT NOTE:

Payment of benefit is subject to the insured meeting and continuing to meet the definition of incapacity applicable and the requirements of The Prudential Assurance Company Limited.

Please refer to the Plan Terms and Conditions for full details including any maximums and limitations.

HOW LONG DO YOU REQUIRE COVER FOR?

	First/Single plan holder	Second plan holder
Plan term required	Years	Years

IMPORTANT NOTES:

(1) If you select decreasing cover on page 8, the sum insured will decrease over the plan term in line with a hypothetical capital and interest mortgage.

(2) The minimum plan term is 10 years.

(3) The plan holder can choose the length of cover required for their plan. However, all cover must cease on or before the plan anniversary immediately prior to the insured person's 70th birthday. For income protection, cover must cease by the insured person's 65th birthday.

Please refer to the Plan Terms and Conditions for full details including any maximums and limitations.

PREMIUM DETAILS

	First/Single plan holder	Second plan holder
1. Regular monthly premium	£	£

Please insert the amount from your illustration and attach a copy of the illustration for each insured to this Application Form.

2. Direct debit collection date	(1st - 28th day)	(1st - 28th day)

Please specify your preferred day for direct debit collections.

IMPORTANT NOTE:

(1) All plan premiums must be paid by direct debit.

(2) If two people are applying for cover please note that each must complete a separate direct debit instruction.

(3) The first direct debit will be collected 14 days after your plan commences. This may include a pro rata payment depending on your selected direct debit collection date, as there has to be one complete calendar month between your 2nd direct debit collection and the plan commencement date. **However, to avoid confusion, we will confirm the payment details to you, before they are collected**.

(4) If two people are using this form to apply for cover, each can choose a separate collection date for their plan.

(5) If more than one signature is required to authorise a direct debit instruction please ensure that all parties sign the direct debit on page 23.

(6) If your adviser will be submitting your application online including a paperless direct debit please note the following:

(a) Joint accounts that require both signatures cannot be used for paperless direct debits. (Please complete the direct debit Instruction on page 23).

(b) Business accounts cannot be used for paperless direct debits. (Please complete the direct debit Instruction on page 23).

(c) The bank account must be in the same name as the plan holder. (If premiums are to be collected from an account not in the plan holder's name, please complete the direct debit Instruction on page 23).

WHEN DO YOU WANT YOUR COVER TO START

	First/Single plan holder	Second plan holder
Do you want your plan to start immediately?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

If you do not wish it to start immediately, it will be delayed until you or your financial adviser tell us to start it. Direct debit collections will not begin until the plan starts. If any insurance you apply for is not accepted on standard terms we will re fer back to you or your financial adviser. The start date cannot be backdated.

FAILURE TO ANSWER THE QUESTIONS HONESTLY AND WITH REASONABLE CARE MAY RESULT IN YOUR CLAIM BEING REJECTED OR NOT PAID IN FULL

THE INSURED'S HEALTH QUESTIONS

IMPORTANT NOTES:

(1) Please read all of the important customer notes on page 3 of this Application Form.

(2) If you prefer, you may complete the health questions in private and return them direct to our Chief Medical Officer (at the address on the back of this form). Please indicate on this form if you have done so.

	First/Single insured	Second insured

1. What is your height and weight? You should give your exact measurements. If unsure of these please check.

* Delete as appropriate		* Delete as appropriate	
Height	ft/m*	Height	ft/m*
Weight	st/kg*	Weight	st/kg*

2a. What is your average consumption of alcohol units per week? (1 unit = 1 single pub measure of spirits/small (125ml) glass of wine or 1/2 pint of standard strength beer, lager or cider)

2b. Have you ever been advised to reduce or cut down your alcohol intake; or has your alcohol intake ever exceeded the recommended weekly amounts of 21 units for males and 14 units for females?

☐ Yes ☐ No	☐ Yes ☐ No
If Yes, please provide details.	**If Yes**, please provide details.

3. Have you smoked or used any tobacco products in the past 12 months?

☐ Yes ☐ No	☐ Yes ☐ No
If Yes, please provide details of **daily** amounts:	**If Yes,** please provide details of **daily** amounts:
Cigarettes	Cigarettes
Cigars	Cigars
Pipe - oz/grams	Pipe - oz/grams
Tobacco - oz/grams	Tobacco - oz/grams
Nicotine replacement products	Nicotine replacement products

IMPORTANT NOTE: We may carry out random tests to confirm the non-smoker status.

4. Have you ever used recreational drugs? This includes cannabis, ecstasy, cocaine, heroin or similar substances.

☐ Yes ☐ No	☐ Yes ☐ No
If Yes, please provide details, including types of drugs and dates of use.	**If Yes**, please provide details, including types of drugs and dates of use.

THE INSURED'S HEALTH QUESTIONS CONT.

First/Single insured | Second insured

5a. Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Note, if the result is negative, the fact of having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

5b. Within the last five years have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU).

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

5c. Within the last five years have you tested positive or been treated for any disease, which was transmitted sexually?

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

If you have answered **YES** to **5a, 5b or 5c** please give full details including the nature and date of tests, the reason for exposure, the countries involved (if applicable) and/or the nature of any sexually transmitted diseases. If you require more space please attach a signed and dated note to this application.

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

	First/Single insured		Second insured	
(a) Cancer, leukaemia, hodgkin's disease, lymphoma, brain or spinal tumour?	☐ Yes	☐ No	☐ Yes	☐ No
(b) Heart disease or disorder – including heart attack, angina, heart murmur, cardiomyopathy, heart valve defect or heart surgery?	☐ Yes	☐ No	☐ Yes	☐ No
(c) Stroke or transient ischaemic attacks (mini-stroke), brain haemorrhage or permanent brain injury through accident?	☐ Yes	☐ No	☐ Yes	☐ No
(d) Multiple sclerosis, epilepsy, paralysis, muscular dystrophy, parkinson's disease (or other movement disorders), motor neurone disease or cerebral palsy?	☐ Yes	☐ No	☐ Yes	☐ No
(e) Disease or disorder of the arteries – including disease in the legs, deep vein thrombosis or the aorta?	☐ Yes	☐ No	☐ Yes	☐ No
(f) Diabetes or sugar in the urine?	☐ Yes	☐ No	☐ Yes	☐ No
(g) Mental illness that has required hospital treatment or referral to a psychiatrist or other specialist?	☐ Yes	☐ No	☐ Yes	☐ No

If you have answered '**Yes**' to any of question 6, please give the details below and on the following page.

First/Single insured Disease/disorders:	Second insured Disease/disorders:

THE INSURED'S HEALTH QUESTIONS CONT.

First/Single insured	Second insured
Date of first symptoms:	Date of first symptoms:
Date of last symptoms:	Date of last symptoms:
Treatment:	Treatment:
Results of investigations:	Results of investigations:
Do you require a follow up review?	Do you require a follow up review?
Are you fully recovered from the condition?	Are you fully recovered from the condition?
Time off work and when:	Time off work and when:

If you require more space please attach a signed and dated note to this application.

7. In the last 5 years have you had any of the following:

	First/Single insured		Second insured	
(a) A lump or growth of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size?	☐ Yes	☐ No	☐ Yes	☐ No
(b) Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?	☐ Yes	☐ No	☐ Yes	☐ No
(c) Optic neuritis, numbness, tingling, facial pain, visual disturbance including blurred vision or double vision, dizziness, chronic fatigue or tiredness?	☐ Yes	☐ No	☐ Yes	☐ No
(d) Seizure, fits, fainting or blackouts?	☐ Yes	☐ No	☐ Yes	☐ No
(e) Any disorder of the digestive system, liver, stomach, pancreas, gall bladder or bowel – including gastric or duodenal ulcer, hepatitis, colitis or crohn's disease?	☐ Yes	☐ No	☐ Yes	☐ No
(f) Any disorder of the kidneys, bladder or prostate – including blood or protein in the urine or urinary tract infections?	☐ Yes	☐ No	☐ Yes	☐ No
(g) Blood disorder or anaemia?	☐ Yes	☐ No	☐ Yes	☐ No
(h) Any disorder of the adrenal, pituitary or thyroid glands?	☐ Yes	☐ No	☐ Yes	☐ No
(i) Any pain or other disease, disorder or problem relating to your back, neck, joints, bones or muscles including arthritis, slipped disc, rheumatism or gout?	☐ Yes	☐ No	☐ Yes	☐ No
(j) Asthma, bronchitis or any other disorder of the lungs or respiratory system?	☐ Yes	☐ No	☐ Yes	☐ No

THE INSURED'S HEALTH QUESTIONS CONT.

	First/Single insured		Second insured	
(k) Any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorders?	☐ Yes	☐ No	☐ Yes	☐ No
(l) Disorder of the eyes including blindness or problems with sight? You can ignore sight problems fully corrected by glasses or contact lenses.	☐ Yes	☐ No	☐ Yes	☐ No
(m) Disorder of the ears including difficulty hearing?	☐ Yes	☐ No	☐ Yes	☐ No
(n) Any gynaecological disorder (including cervical smears) or breast condition for which you have been referred to a specialist or required investigations or treatment?	☐ Yes	☐ No	☐ Yes	☐ No
(o) Any investigation, x-ray, scan or blood test for any condition not already mentioned (or been advised to have any of these)?	☐ Yes	☐ No	☐ Yes	☐ No
(p) A surgical operation for any condition not already mentioned?	☐ Yes	☐ No	☐ Yes	☐ No
(q) Any form of medical attention at a hospital as an inpatient or outpatient for any condition not already mentioned?	☐ Yes	☐ No	☐ Yes	☐ No

If you have answered '**Yes**' to any of question 7, please give the details below.

Disease/disorders:	Disease/disorders:
Date of first symptoms:	Date of first symptoms:
Date of last symptoms:	Date of last symptoms:
Treatment:	Treatment:
Results of investigations:	Results of investigations:
Do you require a follow up review?	Do you require a follow up review?
Are you fully recovered from the condition?	Are you fully recovered from the condition?
Time off work and when:	Time off work and when:

If you require more space please attach a signed and dated note to this application.

THE INSURED'S HEALTH QUESTIONS CONT.

First/Single insured | Second insured

8. In the last 5 years have you been off work for 2 weeks or more for any medical condition, illness or injury? NOTE: You can exclude any medical conditions, illnesses or injuries already disclosed in this form.

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

If Yes, please provide details.

If Yes, please provide details.

If you require more space please attach a signed and dated note to this application.

9a. Are you aware of any other medical condition or symptoms where you intend to seek medical advice or are you waiting for the results of any medical investigation?

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

If Yes, please provide details.

If Yes, please provide details.

9b. Are you currently taking prescribed drugs, medicines, tablets or any other form of treatment for any condition not already mentioned (Oral contraceptives can be disregarded)?

☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No**

If Yes, please provide details.

If Yes, please provide details.

If you require more space please attach a signed and dated note to this application.

10. Before the age of 65, did either of your parents or any brothers or sisters, suffer or die from:

	First/Single insured	Second Insured
(a) Cancer?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
(b) Heart disease, stroke or diabetes?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
(c) Multiple sclerosis or alzheimer's disease?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
(d) Muscular dystrophy, parkinson's disease, motor neurone disease or haemochromatosis?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
(e) Huntington's disease, polycystic kidney disease or polyposis of the colon?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
(f) Any other potentially hereditary disease or disorder?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

If you have answered **Yes** to any of the above please provide full details on the next page.

THE INSURED'S HEALTH QUESTIONS Cont.

First/Single insured – If you have answered **Yes** to any part of question 10, please complete this table.

Relationship			
Illness (if cancer, which part of the body was affected?)			
Age at diagnosis			
Current age			
Age at death (if applicable)			

Second insured – If you have answered **Yes** to any part of question 10, please complete this table.

Relationship			
Illness (if cancer, which part of the body was affected?)			
Age at diagnosis			
Current age			
Age at death (if applicable)			

If you require more space please attach a signed and dated note to this application.

THE INSURED'S DOCTORS DETAILS

First/Single insured

Please provide details of your current doctor:

Name

Address

Postcode

Telephone Number

Second insured

Only complete if different to first Insured

Name

Address

Postcode

Telephone Number

Please give details of your previous doctor if you have changed doctor in the last 6 months. See pages 3 and 17 for consent to access personal files and medical reports.

Name (previous doctor)

Address

Postcode

Telephone number

Name (previous doctor)

Address

Postcode

Telephone number

ACCESS TO MEDICAL REPORTS CONSENT FORM

PLEASE DO NOT ASSUME THAT WE WILL WRITE TO YOUR DOCTOR. IT REMAINS YOUR REPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY.

We may need to request medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988 or in Northern Ireland, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. Your rights under the act are as follows:

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health.
- Any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
- Details (excluding minor self-limiting ailments/conditions) of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:

  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
  - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
  - suicidal thoughts or attempts at suicide; or
  - conditions related to drug or alcohol misuse or smoking or chewing tobacco.

- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalysis (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health; or
- predictive genetic test results

The information you and your doctor provide about your health may result in us:

- refusing to provide insurance;
- increasing premiums above standard rates;
- setting premiums at standard rates;
- setting exclusions or postponing cover

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to:

The Senior Underwriter, Synergy Financial Products Limited, PO Box 1010, St Albans, Herts, AL1 9NB

Please tick the box on page 19 if you want to see the medical report before your doctor sends it to us.

Declaration to Synergy Financial Products Limited, The Prudential Assurance Company Limited.

I/we hereby apply for insurance under Synergy Protect administered by Synergy Financial Products Limited under the Plan Terms and Conditions of Synergy Protect.

By signing below, you will be agreeing to enter into a contract with Synergy Financial Products Limited and The Prudential Assurance Company Limited on the terms set out in the Key Features, Plan Guide, Terms and Conditions and Application Form. You should read these carefully before signing. If you do not understand any point please ask for further information.

I/we have received a Personal Illustration and the Synergy Protect Key Features.

I/we declare that I/We have taken reasonable care to answer the questions honestly and to the best of my/our knowledge. I understand a claim may not be paid in full or may be rejected or my policy may be cancelled if I/we have not

I/we confirm that I/we have read the "Important Customer Notes" section on page 3.

I/we confirm that I/we have read the "Data Protection Act" section on page 5.

I/we confirm that I/we have read the information relating to my/our rights under the "Access to Medical Reports Act" on page 17 and confirm my/our agreement for you to obtain a medical report if required. I/we confirm that it remains my/our responsibility to complete the Application Form correctly, and that I/we cannot rely on my Doctor to provide the information required.

I/we agree that my Financial Adviser may submit this application online.

I/we agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my proposal. You may gather relevant information from other insurers about any other applications for life, critical illness, income protection, or private medical insurance that I have applied for.

I/we authorise those asked to provide medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the start of the plan, or after my death, to support any claim made on the plan proceeds. This information can also be used to maintain management information for business analysis.

I/we understand this application together with any other information provided by myself or my Financial Adviser on my behalf will form the basis of the contracts with Prudential Assurance Company Limited and Synergy Financial Products Limited.

IMPORTANT NOTES:

(1) All insureds and plan holders must sign and date this Application Form on page 19.

(2) Money Laundering Regulations (as amended). Under these regulations, there is a legal requirement to prove the identity of people who wish to enter into a financial contract. You may, therefore, be asked for some evidence of your identity. This will normally be a passport or similar form of identity check with additional proof of address from a gas bill, electricity bill or similar. Synergy Financial Products Limited may also make enquiries when verifying identity. This would include electronic verification through a third party.

Please complete the declaration on the following page.

All of the people insured by this Plan
(and the Plan Holders if different) must sign below.

First/Single Insured

Do you want to see the report before your doctor sends it to us?

Please Tick

☐ **Yes** ☐ **No**

Second Insured

Do you want to see the report before your doctor sends it to us?

Please Tick

☐ **Yes** ☐ **No**

Signature of the First Insured:

Date:

Print Name:

Signature of the Second Insured:

Date:

Print Name:

Signature of the First Plan Holder: If different from the First Insured

Date:

Print Name:

Signature of the Second Plan Holder if different to the Second Insured:

Date:

Print Name:

For Financial Adviser use only

Confirmation of verification of identity- **Private Individual**

Introduction by an FCA Regulated Firm

1 Details of individual (see explanatory notes below)

Full name of customer
Current address Postcode
Previous address if individual has changed address in the last three months Postcode
Date of birth (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

2 Confirmation

I/we confirm that:	(tick only one)
The information in section 1 above was obtained by me/us in relation to the customer, and the evidence I/we have obtained to verify the identity of the customer meets the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG	☐
I believe Synergy Financial Products Limited may rely on Simplified Due Diligence (see note 4 below) based on the amount of the monthly premium on this application.	☐
Signed Date / / 20	
Name in CAPITAL LETTERS	
Position	

3 Details of introducing firm (or sole trader)

Full name of regulated firm (or sole trader)
FCA reference number

Explanatory Notes:

1. A separate confirmation must be completed for each customer (e.g. joint holder's, trustee cases and joint life cases). Where a third party is involved e.g. a payer of contributions who is different from the customer, the identity of that person must also be verified, and a confirmation provided.
2. This form cannot be used to verify the identity of any customer that falls into one of the following categories:
   - Those who are exempt from verification as being an existing client of the introducing firm prior to the introduction of the requirement for such verification.
   - Those whose identity has not been verified by virtue of the application of a permitted exemption under the Money Laundering Regulations; or
   - Those whose identity has been verified using the source of funds as evidence.
3. This confirmation must carry an original signature or an electronic equivalent.
4. The Joint Money Laundering Steering Group guidance notes provide guidance on when a firm can apply Simplified Due Diligence. No verification of identity is required for certain low risk regular premium products of less than 1000 Euro per annum. Synergy Financial Products Limited has imposed a sterling amount of £65 per month or less.

For Financial Adviser use only

Confirmation of verification of identity- **Private Individual**

Introduction by an FCA Regulated Firm

1 Details of individual (see explanatory notes below)

Full name of customer
Current address Postcode
Previous address if individual has changed address in the last three months Postcode
Date of birth (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

2 Confirmation

I/we confirm that:	(tick only one)
The information in section 1 above was obtained by me/us in relation to the customer, and the evidence I/we have obtained to verify the identity of the customer meets the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG	☐
I believe Synergy Financial Products Limited may rely on Simplified Due Diligence (see note 4 below) based on the amount of the monthly premium on this application.	☐
Signed Date / / 20	
Name in CAPITAL LETTERS	
Position	

3 Details of introducing firm (or sole trader)

Full name of regulated firm (or sole trader)
FCA reference number

Explanatory Notes:

1. A separate confirmation must be completed for each customer (e.g. joint holders, trustee cases and joint life cases). Where a third party is involved e.g. a payer of contributions who is different from the customer, the identity of that person must also be verified, and a confirmation provided.
2. This form cannot be used to verify the identity of any customer that falls into one of the following categories:
   - Those who are exempt from verification as being an existing client of the introducing firm prior to the introduction of the requirement for such verification.
   - Those whose identity has not been verified by virtue of the application of a permitted exemption under the Money Laundering Regulations; or
   - Those whose identity has been verified using the source of funds as evidence.
3. This confirmation must carry an original signature or an electronic equivalent.
4. The Joint Money Laundering Steering Group guidance notes provide guidance on when a firm can apply Simplified Due Diligence. No verification of identity is required for certain low risk regular premium products of less than 1000 Euro per annum. Synergy Financial Products Limited has imposed a sterling amount of £65 per month or less.

Adviser Checklist

1) A copy of each customer's illustration is attached.	☐
2) Money laundering forms are submitted for each customer applying for cover (pages 20 and 21).	☐

IMPORTANT NOTE:
If we require the Access to Medical Reports Consent Form we will contact you.

Financial Adviser Details

Adviser name
Company name
Network (if appropriate)
Agency number
Commission requirement

Additional notes:

DIRECT DEBIT INSTRUCTION – The Direct Debit Guarantee

IMPORTANT NOTE: One mandate must be completed for each Insured.

DIRECT Debit

Instruction to your bank/building Society to pay direct debits

First/Single Insured or Plan holder

DIRECT Debit

Please complete parts 1 to 5, the unshaded areas, to instruct your bank/building Society to make payments directly from your account.

Synergy Financial Products Limited, PO Box 1010, St Albans, Herts, AL1 9NB.

1. Full name and postal address of your bank/building Society:

The Manager:

Postcode

2. Name(s) of account holder(s):

Originators identification number | 8 | 4 | 0 | 4 | 3 | 3 |

Originators reference (leave blank) /08

3. Sort code | | | - | | | - | | |

4. Account no. | | | | | | | | |

5. Instruction to your bank/building society and signature(s). Please pay SFP Limited direct debits from the account detailed on this instruction, subject to the safeguards assured by the direct debit guarantee. I understand that this instruction may remain with SFP Limited and, if so, details will be passed electronically to my bank/building Society

Signature Date

Signature Date

Banks and building societies may not accept direct debit instructions for some types of account.

Second Insured or Plan holder

DIRECT Debit

Please complete parts 1 to 5, the unshaded areas, to instruct your bank/building Society to make payments directly from your account.

Synergy Financial Products Limited, PO Box 1010, St Albans, Herts, AL1 9NB.

1. Full name and postal address of your bank/building Society:

The Manager:

Postcode

2. Name(s) of account holder(s):

Originators identification number | 8 | 4 | 0 | 4 | 3 | 3 |

Originators reference (leave blank) /08

3. Sort code | | | - | | | - | | |

4. Account no. | | | | | | | | |

5. Instruction to your bank/building society and signature(s). Please pay SFP Limited direct debits from the account detailed on this instruction, subject to the safeguards assured by the direct debit guarantee. I understand that this instruction may remain with SFP Limited and, if so, details will be passed electronically to my bank/building society

Signature Date

Signature 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.

DIRECT Debit

- This guarantee is offered by all banks and building societies that take part in the direct debit scheme. The efficiency and security of the scheme is monitored and protected by your own bank or building society.
- If the amounts to be paid or the payment dates change, Synergy Financial Products Limited will notify you at least 14 days in advance of your account being debited or as otherwise agreed.
- If an error is made by Synergy Financial Products Limited or your bank or building society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a direct debit at any time by writing to your bank or building society. Please also send a copy of your letter to Synergy Financial Products Limited.

If you have difficulty in reading our literature please call us on 0330 123 9938. We can supply this in a range of formats, including large print and Braille.

Synergy Protect is issued and administered by Synergy Financial Products Limited.

Synergy Financial Products Limited
PO Box 1010
St Albans
AL1 9NB

Client Services & New Business
Telephone: 0330 123 9938
Facsimile: 01727 737819
E-mail: support@sfpl.co.uk
sfpl.co.uk

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