Friends Provident International

Application form

This application form is for residents of the United Arab Emirates only

Applications can only be submitted via financial advisers regulated by the Central Bank of the United Arab Emirates (CBUAE)

Failure to give accurate and complete answers may result in non payment of a claim

Part 1: Introduction

It is most important that you read this part before completing the application form.

Please provide all relevant information and documentation so that we can process your application as soon as possible. Further information may be required during the validation process (i.e. questions arising from the information provided).

Please complete this form in English, using block capitals. If you make a mistake, please cross it out and correct it, initialing any amendments. Please do not use correction fluid or any other method for deleting incorrect information.

If you require more space to write your answers, please attach an additional sheet to this application, and write on this form that you have done so.

1 Disclosure of all relevant information

- **Help us to assess your application by giving us all the information we ask for. All the questions we ask are relevant and important. In this application, you must disclose completely and truthfully all and any information, facts and circumstances of material significance of which you are aware. Information, facts or circumstances are material if they would influence the judgment of a prudent underwriter in determining the premium or determining whether or not to accept the risk. If any material information, fact or circumstance is not disclosed in this application or you misrepresent any material information, fact or circumstance, we may cancel the policy and all or part of any claim may not be paid. If you are in doubt as to whether or not any information is material it is advised to disclose it.**
- **If anything about your health or circumstances changes after you have completed this application, and before we start the cover applied for, you must let us know immediately.**

  We need to know of any changes which would have resulted in different replies to questions asked either: on or resulting from the application form or other questionnaire; or by any doctor or nurse acting on our behalf.

  To inform us of any such change, please telephone our Dubai office on +9714 436 2800.

  Changes would include having, or expecting to have, doctor, hospital or clinic consultations, treatment as an in-patient or out-patient or a blood test for any reason. We also need to know immediately if you change your occupation, country of residence or take up any hazardous sports or pastimes before cover starts.
- If we are advised of any changes we will confirm in writing whether or not any terms quoted will still apply.

2 Terms and conditions

- You should seek guidance from your usual Financial Adviser as to the suitability of the policy to your own particular circumstances.
- Once your application has been processed, you will receive a copy of our policy conditions, along with your personal policy schedule(s). Please ensure you read these documents in full during the 'cooling off' period (please refer to Cancellation rights section in Part 12 of this application form for more details), and that you retain any documents and/or correspondence received from us.

  An electronic copy of the policy conditions can be requested from your Financial Adviser at any time prior to receiving the copy that is sent with your policy schedule(s).
- **Important: Please be aware that the policy conditions sent with your policy schedule(s) will be the ones that apply to your policies; therefore, these documents should be kept safe.**
- A copy of this application form will be provided to you with your policy documents.
- **An Arabic version of this document will be made available upon request.**

3 Medical evidence

We will only pay for medical information which we have specifically requested.

4 Answering the application questions

- Please take reasonable care to ensure that the answers you provide throughout this application form are to the best of your knowledge and belief, true and that no fact has been withheld.
- Please understand and accept that failure to disclose a fact or giving of false information, may give us the right to cancel from inception any policy issued as a result of this application and may invalidate any future claim.
- Please also understand that you must tell Friends Provident International Limited, without delay, if your health or circumstances change before the risk date of the policy.

Details of Insurance Authority (IA) licensed Financial Adviser - to be completed by the Financial Adviser

Company name	
Friends Provident International agency number	
Telephone	

Contact details for acknowledgement/queries on the application.

Contact name	
Phone number	
Email address	
Plan number (if known)	

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Part 2: Personal details of life/lives assured

The life/lives assured is/are the person(s) on whose life (lives) the policy will be written. Please complete in block capitals.

		First (or only) Life	Second Life
1	Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other Male ☐ Female ☐	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other Male ☐ Female ☐
2	Surname/Family name		
3	First name(s)		
4	Current residential address (including street name, town and area code if known)		
5	Correspondence address (if different)		
6	Telephone number(s) (Please provide at least one telephone number for each life assured)	Work Home Mobile	Work Home Mobile
7	Email Address		
8	ID or passport number		
9	Permanent residency visa number (if applicable)		
10	Date of birth (dd/mm/yyyy)		
11	Marital status		
12	Relationship or nature of interest between the two lives to be assured (if applicable)		
13a	Do you have a regular doctor or medical practitioner? If yes, provide **full** name and address of your regular doctor or medical practice/centre including fax number. **Please note we might not contact your doctor. Even if we do, you must still disclose all facts when completing this application.**	Yes ☐ No ☐ Telephone Fax	Yes ☐ No ☐ Telephone Fax
13b	How long has your regular doctor known you?	years	years

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Part 3: Occupation

	First (or only) Life	Second Life
1a What is your occupation? (If you have more than one occupation, please provide full details of each one)		
1b What is the **name** and **address** of your employer and the **nature of your employer's business** (for example, Oil & natural gas, Construction, Financial Services etc)?		
1c Please give details if you work underground, underwater, at heights over 3 metres, offshore or any other hazardous aspects of your occupation	Full details to include percentage of working time spent at heights and average and maximum heights worked at (if applicable.)	Full details to include percentage of working time spent at heights and average and maximum heights worked at (if applicable.)

Politically Exposed Persons

A Politically Exposed Person (PEP) is a person who is, or who has been, entrusted with prominent public functions. This also includes their close family members and their close associates.

Examples of PEPs include political figures, member of the judiciary, diplomatic service officers, managers and supervisors of state owned enterprises and senior ranking military officers.

	First (or only) Life	Second Life
1a Are you, any of your family members or any of your close associates a PEP? If Yes, please provide the following details and complete the supplementary Source of Wealth Form.	Yes ☐ No ☐	Yes ☐ No ☐
1b Surname		
1c Forename(s)		
1d Position held as PEP		
1e Country position held		
1f Date position held	From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐	From ☐☐ ☐☐ ☐☐☐☐ To ☐☐ ☐☐ ☐☐☐☐
1g If the PEP is a family member or close associate, please confirm the relationship		

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Part 4: Plan Details

Required currency USD ($) ☐ GBP (£) ☐ EURO (€) ☐ AED ☐

Please see the information in Part 14 before choosing your premium frequency and premium payment method.

Premium payable Monthly ☐ Annually ☐

Premium payment method Bank Standing order (BSO) ☐ Credit or Debit card (Not for AED policies) ☐ Cheque/ post-dated cheque ☐ Bank transfer (Annual premiums only) ☐

A – Life Cover – Level Sum Assured

First Life only	Second Life only	Joint Life
Sum assured	Sum assured	Sum assured
Policy term (years)	Policy term (years)	Policy term (years)
Premium payment type	Premium payment type	Premium payment type
Regular ☐ Accelerated ☐	Regular ☐ Accelerated ☐	Regular ☐ Accelerated ☐
Premium payment term (years)	Premium payment term (years)	Premium payment term (years)
☐ Total and Permanent Disability Benefit (Tick if required)	☐ Total and Permanent Disability Benefit (Tick if required)	☐ Total and Permanent Disability Benefit (Tick if required)

B – Life or Earlier Critical Illness Cover – Level Sum Assured

First Life only	Second Life only	Joint Life
Sum assured	Sum assured	Sum assured
Policy term (years)	Policy term (years)	Policy term (years)
Premium payment type	Premium payment type	Premium payment type
Regular ☐ Accelerated ☐	Regular ☐ Accelerated ☐	Regular ☐ Accelerated ☐
Premium payment term (years)	Premium payment term (years)	Premium payment term (years)

C – (Stand-alone) Critical Illness Cover – Level Sum Assured

First Life only	Second Life only	Joint Life
Sum assured	Sum assured	Sum assured
Policy term (years)	Policy term (years)	Policy term (years)
Premium payment type	Premium payment type	Premium payment type
Regular ☐ Accelerated ☐	Regular ☐ Accelerated ☐	Regular ☐ Accelerated ☐
Premium payment term (years)	Premium payment term (years)	Premium payment term (years)

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Part 4: Plan Details continued

D – Life Cover – Decreasing Sum Assured

First Life only

Sum assured

Policy term (years)

Premium payment type

Regular ☐ Accelerated ☐

Premium payment term (years)

Interest rate 7% ☐ or 11% ☐

☐ Total and Permanent Disability Benefit (Tick if required)

Second Life only

Sum assured

Policy term (years)

Premium payment type

Regular ☐ Accelerated ☐

Premium payment term (years)

Interest rate 7% ☐ or 11% ☐

☐ Total and Permanent Disability Benefit (Tick if required)

Joint Life

Sum assured

Policy term (years)

Premium payment type

Regular ☐ Accelerated ☐

Premium payment term (years)

Interest rate 7% ☐ or 11% ☐

☐ Total and Permanent Disability Benefit (Tick if required)

E – Life or Earlier Critical Illness Cover – Decreasing Sum Assured

First Life only

Sum assured

Policy term (years)

Premium payment type

Regular ☐ Accelerated ☐

Premium payment term (years)

Interest rate 7% ☐ or 11% ☐

Second Life only

Sum assured

Policy term (years)

Premium payment type

Regular ☐ Accelerated ☐

Premium payment term (years)

Interest rate 7% ☐ or 11% ☐

Joint Life

Sum assured

Policy term (years)

Premium payment type

Regular ☐ Accelerated ☐

Premium payment term (years)

Interest rate 7% ☐ or 11% ☐

Start date

Should anything about your health or other circumstances change before we have started the policy you have applied for, you must tell us immediately. We will then confirm in writing whether any terms we have quoted will remain available. Failure to notify us of any such change may result in the policy becoming void and the benefits not becoming payable

We will start your policy immediately if your application is accepted on our normal terms, unless you state a date below on which you would like it to start or have instructed us otherwise.

If your application is not accepted on our normal terms, the policy will not start until we receive written notification of your acceptance of any revised terms we offer, and your instruction for the policy to start.

We also need to have received your first premium or a completed banker's standing order or credit card instruction.

Effective date (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Failure to give accurate and complete answers may result in non payment of a claim

Part 5: Residential and travel details

		First (or only) Life	Second Life
1	What are your nationalities? Please list all. If you intend to change your country of residence, please provide full details.		
2	Country of birth		
3	Town of birth		
4	What is your current country of residence?		
5	What is the legal basis of your stay in the current country of residence (for example permanent resident visa)?		
6a	How long have you lived in your current country of residence?		
6b	How long do you intend to stay in your current country of residence? If you intend to change your country of residence, please provide full details.		
7	In which countries have you lived and for how long?		
8a	Has your occupation involved travel outside your current country of residence in the last two years? If Yes, please give details including **specific countries** visited, dates and duration of stay.	Yes ☐ No ☐ Details (Include countries, dates and durations)	Yes ☐ No ☐ Details (Include countries, dates and durations)
8b	Do you expect your occupation to involve travel outside your current country of residence in the future? If Yes, please give details including **specific countries** to be visited, dates and duration of stay.	Yes ☐ No ☐ Details (Include countries, dates and durations)	Yes ☐ No ☐ Details (Include countries, dates and durations)

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Part 6: Recreation details

To qualify as a 'non-smoker' you must not have used any form of tobacco or nicotine products within the last 12 months.

		First (or only) Life	Second Life
1	Have you smoked or used any form of tobacco (for example cigarettes, cigars, pipe tobacco, shisha pipe) or nicotine product (for example nicotine patches, nicotine gum, e-cigarettes) in the last 12 months?	Yes ☐ No ☐ (Random tests may be carried out to verify non-smoker status)	Yes ☐ No ☐
	If yes, what form and how much a day?	e.g. cigarettes, 20 per day	e.g. cigarettes, 20 per day
	If you have given up, when did you last use tobacco, what form and how much a day did you previously use?		
2a	Do you drink alcohol?	Yes ☐ No ☐	Yes ☐ No ☐
	If yes, how many units per week? (1 unit = a single measure of spirits or 1 glass of wine (125ml) or 1/2 pint (250ml) of beer).		
2b	Have you ever been advised by a doctor or any other medical practitioner to reduce or stop your alcohol consumption on medical grounds or have you ever taken part in counselling, therapy or a programme with the aim of reducing or stopping your alcohol consumption?	Yes ☐ No ☐ Details	Yes ☐ No ☐ Details
3	In the last 7 years have you taken any non-prescription drugs (for example LSD, ecstasy, cocaine, heroin, cannabis, anabolic steroids etc)?	Yes ☐ No ☐ Details	Yes ☐ No ☐ Details
4	Do you take part in any hazardous sport or pastime or do you intend to start? (Mountaineering, motor sport, sub-aqua diving and private flying are examples but you should include any activity that is hazardous. You do not need to include sports such as horse riding, skiing, football, rugby, hockey, cricket or racquet sports)	Yes ☐ No ☐ Details	Yes ☐ No ☐ Details

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Part 7: Financial details

Where requested please give us as much information as possible.

For higher sums assured we may require further evidence. Where possible we have asked for this to be attached to the application form so we can underwrite this as soon as possible. To determine financial underwriting requirements the following currency conversions will be used:

US Dollars	British pounds	Euros	UAE dirhams
500,000	285,000	421,800	1,840,000
1,000,000	565,000	836,000	3,680,000
2,000,000	1,125,000	1,665,000	7,360,000
5,000,000	2,850,000	4,218,000	18,400,000

You are reminded that your answers in this section form part of your application and failure to give accurate and complete answers may result in non-payment of a claim.

		First (or only) Life		Second Life	
1a	Annual earned income	Currency (eg. USD)		Currency (eg. USD)	
		Amount		Amount	
1b	Last year annual earned income	Currency (eg. USD)		Currency (eg. USD)	
		Amount		Amount	

2a **First (or only) life**

Do you have any existing life, disability, or critical illness insurance on your life? (If yes, please give details below) Yes ☐ No ☐

Type of cover (e.g. Life, critical illness, etc	Country of insurance	Name of insurer	Sum assured (including currency)	Start date and term	Reason for policy

Second Life

Do you have any existing life, disability, or critical illness insurance on your life? (If yes, please give details below) Yes ☐ No ☐

Type of cover (eg Life, critical illness, etc	Country of insurance	Name of insurer	Sum assured (including currency)	Start date and term	Reason for policy

2b Are any of these policies to be cancelled once this application is in force?

First (or only) Life: Yes ☐ No ☐

Company and policy reference

Second Life: Yes ☐ No ☐

Company and policy reference

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Financial details (continued)

2c If total amount of cover in existence, plus this application, is greater than either US$2M of life assurance or US$500,000 of critical illness insurance, or equivalent, please attach evidence of earned income for the main earner.

Please tick if attached ☐

(e.g. latest tax statement, statement from employer, last 3 months' payslips)

	First (or only) Life	Second Life
3 Apart from the plans mentioned in Part 7, 3a, have you applied to any other company for life, disability or critical illness insurance in the last 12 months or are you about to?	Yes ☐ No ☐	Yes ☐ No ☐
	Company	Company
	Date	Date
	Details including sums assured and reason for policies	Details including sums assured and reason for policies
	Is only one application to proceed?	Is only one application to proceed?
4 Have you ever applied for life assurance, insurance against 'critical illness' or income protection / disability insurance and been turned down or asked to pay a higher premium or have other special terms been imposed?	Yes ☐ No ☐	Yes ☐ No ☐
	Company	Company
	Full details including reason for adverse decision, company and sum assured	Full details including reason for adverse decision, company and sum assured
	Date	Date

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Financial details (continued)

5 Please complete one section from **either** personal cover (a) **or** business protection (b)

a) Personal Cover

Complete each appropriate section

☐ Personal protection (for example family cover)

	First (or only) Life	Second Life
Please tell us the relationship and ages of any dependents		

Please contact Friends Provident International Limited Middle East to discuss requirements for sums assured greater than US$4M.

☐ Personal loan protection (including mortgage)

What is the reason for the loan? If it is for a mortgage, please tell us whether it is for your own main residence or investment.	
Name of lender	
Amount and duration of loan	
Is the loan conditional on issue of this policy?	Yes ☐ No ☐

If the sum assured is above US$1M for life assurance or US$500,000 for critical illness insurance, or equivalent, please attach a copy of the loan offer letter or evidence of the debt. Please tick if attached ☐

b) Business Protection

This includes keyman protection, partnership or shareholder protection or a loan taken out on behalf of a business.

What is the reason for the cover and how was this sum assured derived?	

If the sum assured is above US$1M for life assurance or US$500,000 for critical illness insurance, or equivalent, please complete our Business Financial Underwriting Questionnaire and attach to this application. Please tick if attached ☐

Part 8: Family history

First (or only) Life

Before the age of **60**, have any of your natural parents, brothers or sisters had, or died from, heart disease, stroke, diabetes, cancer, Huntington's disease, polycystic kidney disease, polyposis of the colon, multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neurone disease, muscular dystrophy or any hereditary disorder not already listed above?

Yes ☐ No ☐

If Yes, please complete the relevant section(s) below with details of any of the conditions listed above. Please state the **age at onset of the medical condition** and in the case of cancer, which part of the body was **first affected**.

Relationship to you of person affected	Medical condition	Age at **onset** of condition

Second Life

Before the age of **60**, have any of your natural parents, brothers or sisters had, or died from, heart disease, stroke, diabetes, cancer, Huntington's disease, polycystic kidney disease, polyposis of the colon, multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neurone disease, muscular dystrophy or any hereditary disorder not already listed above?

Yes ☐ No ☐

If Yes, please complete the relevant section(s) below with details of any of the conditions listed above. Please state the **age at onset of the medical condition** and in the case of cancer, which part of the body was **first affected**.

Relationship to you of person affected	Medical condition	Age at **onset** of condition

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Part 9: Health questions – First (or only) Life

All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we may have the legal right to cancel any policy issued as a result of your application and to not pay any claim.

If the answer to any question is 'Yes' please give full details disclosing all facts as they can influence the assessment and acceptance of the application.

1a What is your height? _____ cm

1b What is your weight? _____ kg

1c Apart from intentional weight loss (e.g. diet) or pregnancy, have you lost more than 6 kilograms in the last six months? Yes ☐ No ☐

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

a Cancer, leukaemia, Hodgkin's disease, lymphoma or a brain or spinal tumour? Yes ☐ No ☐

b Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat? Yes ☐ No ☐

c A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage? Yes ☐ No ☐

d Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia? Yes ☐ No ☐

e Visual disturbance, blurred or double vision, optic or retrobulbar neuritis? Yes ☐ No ☐

f Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which you consulted a doctor or hospital? Yes ☐ No ☐

g A disorder of the digestive system (stomach, liver, oesophagus, gallbladder, pancreas or bowel) such as reflux, ulcers, recurrent indigestion, persistent constipation or diarrhoea for which you have consulted a doctor, or any gastric surgery such as a gastric band or sleeve? Yes ☐ No ☐

h Any disorder of the skin or reproductive organs including prostate, testicles, breasts, cervix, uterus, ovaries or fallopian tubes? Yes ☐ No ☐

i Any disorder of the blood such as anaemia, thalassaemia or sickle cell disease? Yes ☐ No ☐

j Have you ever tested **positive** for HIV, Hepatitis B or C or are you awaiting the results of such a test? (If the result was negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

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Health questions – First (or only) life (continued)

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

a Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance? Yes ☐ No ☐

b Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised? Yes ☐ No ☐

c Asthma, bronchitis, tuberculosis, coughing with blood or any chest, lung or breathing disorder? Yes ☐ No ☐

d Recurrent headache for which you have consulted a doctor or any epilepsy, seizure, fit or blackout? Yes ☐ No ☐

e Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore sight problems corrected by glasses or contact lenses but you must tell us about all hearing problems, even if corrected by hearing aid(s)) Yes ☐ No ☐

f Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which you have consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which you have taken time off work? Yes ☐ No ☐

g Any form of liver disorder including jaundice, hepatitis or cirrhosis? Yes ☐ No ☐

h Diabetes, Crohn's disease or colitis? Yes ☐ No ☐

i Any disorder of the kidneys? Yes ☐ No ☐

j Treatment or a positive test for any disease which was transmitted sexually? Yes ☐ No ☐

k (i) Any mental illness or eating disorder or have you attempted self-harm or taken an overdose? Yes ☐ No ☐

(ii) Any other feeling of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner? Yes ☐ No ☐

l Within the last 5 years have you been exposed to the risk of HIV infection? (HIV can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

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Health questions – First (or only) life (continued)

4 In the last 5 years, other than for those conditions you have already mentioned:

a Have you had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient? Yes ☐ No ☐

b Have you had, or been advised to have, any medical investigation, x-ray, scan or test? Yes ☐ No ☐
(For this question, you do not need to give details of occasional consultations with your regular doctor for colds, flu, or consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal)

c Have you been prescribed any drug, medicine or tablet, or have you had any other form of medical treatment (for example physiotherapy, psychotherapy)? Yes ☐ No ☐

d Have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have **not** consulted a doctor, hospital or medical practitioner? Yes ☐ No ☐
(For this question, you do not need to give details of colds and flu which have lasted less than 2 weeks in total)

e Have you had any disability, illness, operation or injury not mentioned above? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

5 In the next 12 months are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation? Yes ☐ No ☐

6 Other than the information you have already provided, have you ever had an illness or medical condition that has lasted more than 3 months and which affected your ability to study or perform normal daily activities or for which you took more than 2 weeks off work? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

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Health questions – First (or only) life (continued)

Additional information

Failure to give accurate and complete answers may result in non payment of a claim

Part 9: Health questions – Second Life

All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we may have the legal right to cancel any policy issued as a result of your application and to not pay any claim.

If the answer to any question is 'Yes' please give full details disclosing all facts as they can influence the assessment and acceptance of the application.

1a What is your height? _____ cm

1b What is your weight? _____ kg

1c Apart from intentional weight loss (e.g. diet) or pregnancy, have you lost more than 6 kilograms in the last six months? Yes ☐ No ☐

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

a Cancer, leukaemia, Hodgkin's disease, lymphoma or a brain or spinal tumour? Yes ☐ No ☐

b Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat? Yes ☐ No ☐

c A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage? Yes ☐ No ☐

d Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia? Yes ☐ No ☐

e Visual disturbance, blurred or double vision, optic or retrobulbar neuritis? Yes ☐ No ☐

f Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which you consulted a doctor or hospital? Yes ☐ No ☐

g A disorder of the digestive system (stomach, liver, oesophagus, gallbladder, pancreas or bowel) such as reflux, ulcers, recurrent indigestion, persistent constipation or diarrhoea for which you have consulted a doctor, or any gastric surgery such as a gastric band or sleeve? Yes ☐ No ☐

h Any disorder of the skin or reproductive organs including prostate, testicles, breasts, cervix, uterus, ovaries or fallopian tubes? Yes ☐ No ☐

i Any disorder of the blood such as anaemia, thalassaemia or sickle cell disease? Yes ☐ No ☐

j Have you ever tested **positive** for HIV, Hepatitis B or C or are you awaiting the results of such a test? (If the result was negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

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Health questions – Second life (continued)

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

a Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance? Yes ☐ No ☐

b Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised? Yes ☐ No ☐

c Asthma, bronchitis, tuberculosis, coughing with blood or any chest, lung or breathing disorder? Yes ☐ No ☐

d Recurrent headache for which you have consulted a doctor or any epilepsy, seizure, fit or blackout? Yes ☐ No ☐

e Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore sight problems corrected by glasses or contact lenses but you must tell us about all hearing problems, even if corrected by hearing aid(s)) Yes ☐ No ☐

f Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which you have consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which you have taken time off work? Yes ☐ No ☐

g Any form of liver disorder including jaundice, hepatitis or cirrhosis? Yes ☐ No ☐

h Diabetes, Crohn's disease or colitis? Yes ☐ No ☐

i Any disorder of the kidneys? Yes ☐ No ☐

j Treatment or a positive test for any disease which was transmitted sexually? Yes ☐ No ☐

k (i) Any mental illness or eating disorder or have you attempted self-harm or taken an overdose? Yes ☐ No ☐

(ii) Any other feeling of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner? Yes ☐ No ☐

l Within the last 5 years have you been exposed to the risk of HIV infection? (HIV can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

Failure to give accurate and complete answers may result in non payment of a claim

Health questions – Second life (continued)

4 In the last 5 years, other than for those conditions you have already mentioned:

a Have you had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient? Yes ☐ No ☐

b Have you had, or been advised to have, any medical investigation, x-ray, scan or test? Yes ☐ No ☐
(For this question, you do not need to give details of occasional consultations with your regular doctor for colds, flu, or consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal)

c Have you been prescribed any drug, medicine or tablet, or have you had any other form of medical treatment (for example physiotherapy, psychotherapy)? Yes ☐ No ☐

d Have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have **not** consulted a doctor, hospital or medical practitioner? Yes ☐ No ☐
(For this question, you do not need to give details of colds and flu which have lasted less than 2 weeks in total)

e Have you had any disability, illness, operation or injury not mentioned above? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

5 In the next 12 months are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation? Yes ☐ No ☐

6 Other than the information you have already provided, have you ever had an illness or medical condition that has lasted more than 3 months and which affected your ability to study or perform normal daily activities or for which you took more than 2 weeks off work? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary	Name, address, tel/fax of doctor or clinic/hospital attended.

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Health questions – Second life (continued)

Additional information

Failure to give accurate and complete answers may result in non payment of a claim

Part 10a: Applicant(s) details

The Applicant(s) is/are the person(s) who are to be the owner(s) of the policy

Is/are the applicant(s):

- ☐ **the first (or only) life assured?**
- ☐ **the second life assured?**
- ☐ **both lives assured?**
- ☐ **neither life/lives assured? If neither, please complete Part 10b in full.**

Part 10b: To be completed when applicant(s) are not life/lives assured.

		First (or only) life	Second life
1	Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female ☐	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female ☐
2	Surname/Family name		
3	First name(s)		
4	Company/trust name		
5	Current address (including street name, town and area code if known)		
6	Telephone number(s)	Work Home	Work Home
7	Email Address		
8	ID or passport number		
9	Date of birth (dd/mm/yyyy)		
10	Marital status		
11	Nationality		
12	Town of birth		
13	Country of birth		
14	Country of permanent residence (if different to above)		
15	Relationship or nature of interest in the person(s) named in Part 2		

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Part 11: Access to existing medical reports

Please note we might not contact your doctor. Even if we do, you must still disclose all the facts when completing this application form.

We may need to get 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.

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.

We ask your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C; or
- Any sexually-transmitted diseases unless there could be long-term effects on your health.

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

- Refusing to provide insurance;
- Increasing premiums above standard rates;
- Applying an exclusion to the cover; or
- Setting premiums at standard rates.

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

The Chief Medical Officer, c/o Friends Provident International Limited, Emaar Square, Building 6, Floor 5, PO Box 215113, Dubai, United Arab Emirates.

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Part 12: Declaration

This Declaration must be signed by all persons involved in this application.

1 • This application is my official request to enter into a contract with Friends Provident International Limited providing the foregoing policy. I understand and accept that the contract will be on Friends Provident International Limited's normal terms and conditions.

• I understand and accept that Friends Provident International Limited is subject to the supervisory arrangements and laws of the United Arab Emirates and the Isle of Man.

• I understand and accept that International Protector Middle East+ is governed by the laws of the United Arab Emirates and all disputes relating to a policy shall be subject to the jurisdiction of the courts of the United Arab Emirates, except as otherwise expressly agreed by the parties in writing.

• I understand and accept that this application can only be accepted by employees of Friends Provident International Limited and that no other parties have the necessary authority to create a binding contract.

2 • I/We acknowledge that in the event of any premium tax or withholding tax being levied in my/our country of residence it will be my/our responsibility to increase the regular premium by an amount equal to the liability or to settle the liability directly with the relevant tax authorities.

3 • Where I am a life assured but not an applicant, I consent for this application to proceed on my life.

4 • I understand and accept Friends Provident International Limited may require sight of my medical records to consider a claim.

• I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual organisation or government office that has any records or knowledge of me or my health to disclose to Friends Provident International Limited any information for the purpose of considering a claim. This authorisation shall irrevocably bind my successors and assigns and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

5 • I understand that information given to Friends Provident International Limited in connection with this application may be used by Friends Provident International Limited in its consideration of any claim in future and may be shared with a third party e.g. medical examiner, to help in the assessment of a claim.

• I understand that you will pass the information about any claim concerning critical or disability illness insurance to the Association of British Insurers (ABI) so that they can make it available to other insurers. I also understand that, in response to any searches you make in connection with this claim, the ABI may pass you information it has received from other insurers.

6 • I understand and accept that the terms and conditions and a copy of this completed application are available on request and that I should retain any documents or correspondence received from Friends Provident International Limited in relation to my policy.

• I understand and accept that where I am applying on the advice of a Financial Adviser, that Financial Adviser is acting on my behalf and not as an agent of Friends Provident International Limited.

7 • **I have read Part 1 – Introduction and my answers to the questions in this application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no fact has been withheld. I understand I must ensure that all facts I disclosed to my Financial Adviser in answer to the questions in this application are accurately recorded in this application. I understand and accept that failure to disclose a fact or the giving of false information may give Friends Provident International Limited the right to cancel from inception any policy issued as a result of this application and may invalidate any future claim.**

• **I understand that I must tell Friends Provident International Limited without delay if my health or circumstances change before Friends Provident International Limited assumes risk for the policy applied for.**

8 • I accept that if I am required to have a medical examination, the replies to the medical examiner's questions will form part of this application.

9 • **I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess this application.** You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance on my life that I have applied for. I authorise those asked to provide medical and policy information when they see a copy of this consent form.

10 • I confirm that the information included in this application form has been entered by myself or with my knowledge and that the signature placed on the application is my signature.

Cancellation rights

You may cancel your policy within 30 days from the day you receive notice from us of your cancellation rights and all contractual documents. These will be sent to you once your policy has been set up.

If you exercise this right to cancel your policy, we will refund your premium. We reserve the right to deduct any reasonable cost incurred for medical tests required for underwriting purposes, but if we do this, we will send you a receipt and your medical reports.

If you wish to cancel you should follow the instructions in the notice from us of your cancellation rights. Upon cancellation, the policy will terminate immediately.

Data Protection

Please read this privacy notice carefully. Please be aware that this is a short version of our privacy policy and you should visit **www.fpinternational.com/legal/privacy-and-cookies** to view the full policy.

Friends Provident International Limited ("FPIL") is the controller of your personal data processed in connection with this application and product. The data which we process is that which you provide in this form such as your names, contact details and information about medical history. As well as obtaining data directly from yourself, we may obtain additional information from your doctor(s) as further described in this application form.

We use your information to process and underwrite your application, administer your policy and handle any claims, to help detect and prevent fraudulent activity, and for customer profiling and marketing.

Failure to give accurate and complete answers may result in non payment of a claim

Declaration (continued)

We only retain your data for as long as is necessary for the maintenance of your contract, or for legal or regulatory requirements.

We may share your data with third parties who provide services to us, some of whom may be located outside of the Isle of Man, European Economic Area (EEA), or country in which your data was collected. In these cases we make sure that your data is protected to the same standards as in the Isle of Man, EEA, or country of data collection. We may also share your data with law enforcement and regulatory bodies, other insurers, your insurance intermediary and their service providers.

Data protection laws require us to tell you what legal basis we use for processing your personal data. In general, the processing is necessary to perform a contract with you, or to take steps requested by you before entering into this contract.

We will not normally carry out any direct marketing campaigns but if we do, we will always contact you first and give you the opportunity to opt in to direct marketing before any communications of this nature take place.

We may process data about you which the law considers to be sensitive, in particular health information. In this case, we base our processing on your freely given, informed, specific consent or that the processing is necessary for the establishment, exercise or defence of legal claims. We may also process this type of data about other people you wish to insure such as family members. Please tell these people to read this privacy notice and our privacy policy so that they understand how FPIL may use their personal data.

By proceeding with this application:

- **You understand that we will use information about you, including information about health, for the above purposes.**
- **You are confirming that any other person (e.g. a family member or other individual covered by your insurance policy, or whose information is relevant to use providing this policy coverage) whose information you are providing understands and has no concerns about their information being used in this way.**

NOTE: If you have any concerns about use of information for these purposes, you should not proceed with this application as we may be unable to provide you with a policy. You can also contact us at any time if you would like to ask us to cease using your information, but this may result in your policy being cancelled.

You have various rights in relation to your personal data including accessing your data, and in some limited circumstances objecting to processing or having your data erased.

You can find out more information about how to exercise these rights and details of who to contact with queries on our privacy practices by viewing our full privacy policy available on our website **www.fpinternational.com/legal/privacy-and-cookies** or it can be provided upon request from our Data Protection Officer, Friends Provident International Limited, Royal Court, Castletown, Isle of Man, British Isles IM9 1RA.

The terms of the Policy and the Declarations in this application form describe circumstances in which We will be exempt from liability under the Policy or which may lead to nullification or avoidance of the Policy or a limitation of Your right(s) as Policyholder. By signing below You confirm that you have read, understand and accepted the terms and conditions of the Policy and the Declarations in full and agree not to rely on any law or regulation or other grounds to argue to the contrary.

	First (or only) Life Assured (who will also be the applicant if Part 10b not completed)	Second Life Assured (who will also be the applicant if Part 10b not completed)
Signature		
	I give explicit consent to capture and process my medical/lifestyle data	**I give explicit consent to capture and process my medical/lifestyle data**
Name (block capitals)		
Date (dd/mm/yyyy)		

* Application must be received by Friends Provident International Limited within six weeks of the date of signing

Only complete the following if Part 10 is completed

	First applicant (if applicable)	Second applicant (if applicable)
Signature		
Name (block capitals)		
Date (dd/mm/yyyy)		
Capacity		

Complete the following for all applications

Country where advice given	
Country where application signed	

Failure to give accurate and complete answers may result in non payment of a claim

Part 13: Appointment of Third Party Payee as Beneficiary

You may use this section to nominate a beneficiary to receive the death benefits. Important: Using this form may not be an effective solution if your objective is to reduce the inheritance tax/estate duties payable by your estate on death. We recommend that you obtain legal advice.

* Delete as appropriate

To: Friends Provident International Limited

Subject to any future revocation or appointment, I/we* hereby appoint the following person/persons* as beneficiary in the share / shares* indicated below.

This appointment does not apply to any Critical Illness and Disability Benefit, Terminal Illness Benefit or Total and Permanent Disability Benefit if included in the policy.

	Third Party Payee 1	**Third Party Payee 2**
Surname of the Payee(s)		
First name		
Date of birth		
Relationship (if any)		
Address		
Email		
Telephone		
Nationality		
% Share	%	%

	Third Party Payee 3	**Third Party Payee 4**
Surname of the Payee(s)		
First name		
Date of birth		
Relationship (if any)		
Address		
Email		
Telephone		
Nationality		
% Share	%	%

Failure to give accurate and complete answers may result in non payment of a claim

Certified identification and verification of residential address for each beneficiary will be required at the time of the claim.

In the event that at the time of any payment you are unable to contact the beneficiary, you should make enquiries of the following person/ persons* for the purposes of locating the beneficiary:

Name of contact	
Address	
Telephone number	
Email address	

If no contact name is given, this will not affect the validity of this appointment. Names and details of other contact persons may be attached if desired.

I/We* confirm that I/we* have taken legal advice before signing this form or I/we* have elected not to do so.

I/We* also understand that the beneficiary appointment made on this form shall be revoked by any surrender assignment or disposal of the policy and by my death/the death of the survivor of us* if at my death/the death of the survivor of us* I am/we are* survived by other persons named as life assured on the schedule to the policy.

This form shall form part of the policy and the appointment is made in accordance with the relevant provision of the policy.

Signed (All joint policyholders must sign)

Signature		
Date (dd/mm/yyyy)		
Signature		
Date (dd/mm/yyyy)		

Failure to give accurate and complete answers may result in non payment of a claim

Part 14: Payment Details

Banker's standing order/telegraphic transfer

Most banks insist on completion of their own standing order form. Please contact your own bank for setting up your standing order after we have confirmed your premium amount.

Please ensure when setting up the standing order all premiums need to be paid **net of charges** to ensure the full premium amount is received by us.

Please forward a copy of the standing order form stamped with the official bank stamp.

Please take care to ensure the correct account is used on the standing order (see below for details)

Cheque/post dated cheques

Please make cheques payable to **Friends Provident International Limited**. These should be forwarded through your Financial Adviser, or alternatively can be sent directly to us at the address below.

Please do not forward cheques until Friends Provident International has confirmed your premium, following underwriting.

Please ensure all cheques are clearly referenced on the reverse with your policy number

Friends Provident International Limited
Building 6, Floor 5
Emaar Square
PO Box 215113
Dubai
UAE

This account can be used when paying for GBP premiums from any currency

Bank	HSBC
Postal address	8 Canada Square, London E14 5HQ, United Kingdom
Account name	Friends Provident International Limited
Sort Code	40-19-38
SWIFT/BIC Code	MIDLGB22
Account number	22566621
IBAN	GB86MIDL40193822566621
The transfer amount should be written in GBP	GBP

OR

Bank	HSBC, Dubai
Postal address	PO Box 66 Dubai, UAE
Account name	Friends Provident International Limited
SWIFT/BIC Code	BBMEAEAD
Account number	025-171067-212
IBAN	AE250200000025171067212

Failure to give accurate and complete answers may result in non payment of a claim

Payment details (continued)

This account can be used when paying for EUR or USD premiums from any currency except AED

Bank	HSBC
Postal address	8 Canada Square, London E14 5HQ, United Kingdom
Account name	Friends Provident International Limited
Sort Code	40-05-15
SWIFT/BIC Code	MIDLGB22
EUR Account number	58980092
USD Account number	58980076
EUR IBAN:	GB95MIDL40051558980092
USD IBAN:	GB42MIDL40051558980076
The transfer amount should be written in EUR or USD	EUR or USD

This account can be used when paying for AED premiums from an AED account only

Bank	HSBC, Dubai
Postal address	PO Box 66 Dubai, UAE
Account name	Friends Provident International Limited
SWIFT/BIC Code	BBMEAEAD
Account number	025-171067-437
IBAN:	AE610200000025171067437
The transfer amount should be written in AED	AED

This account can be used when paying for USD premiums from an AED account.

Bank	HSBC
Postal address	PO Box 66 Dubai, UAE
Account name	Friends Provident International Limited
SWIFT/BIC Code	BBMEAEAD
Account number	025-171067-211
IBAN:	AE520200000025171067211
The transfer amount should be written in AED	AED

This account can be used when paying for USD premiums from any currency.

Bank	HSBC
Postal address	PO Box 66 Dubai, UAE
Account name	Friends Provident International Limited
SWIFT/BIC Code	BBMEAEAD
Account number	025-171067-211
IBAN:	AE520200000025171067211
The transfer amount should be written in USD	AED

Failure to give accurate and complete answers may result in non payment of a claim

Payment details (continued)

Credit Card Authority

Available for sterling, US dollar and Euro monthly and annual payments.

This form supersedes any previous instructions held.

Please use BLOCK CAPITALS

I authorise Friends Provident International Limited, Royal Court, Castletown, Isle of Man, British Isles, IM9 1RA;
Telephone: +44(0) 1624 821212 to charge the premium below, to my credit card account for this insurance policy. This authorisation is to remain in effect until I cancel it by written notification to Friends Provident International Limited at least 30 days in advance of the intended date of cancellation.

Name of cardholder _____ Bank _____

Credit card number _____ _____ _____ _____

Expiry date _____ (month) _____ (year)

Mastercard ☐ VISA credit card ☐

with sum of (premium amount if known)
Please leave blank*

Currency

Collected on the (premium due date)
(dd/mm/yyyy) Please leave blank*

And on the same day until further notice Monthly ☐ Yearly ☐

Address of credit card holder
(as held by the card provider)

The cardholders address should be the same as that of the applicant(s). If it is not, please provide reason why

Signature

Date (dd/mm/yyyy)

Important notes

1 Please note that debit cards cannot be accepted for premium payments.

2 Please note that some credit cards cannot be used outside their country of issue and therefore we strongly recommend that you contact your card issuer to ensure your card can be used in this instance.

* I understand that Friends Provident International Limited will complete these once the premium amount is finalised

Important information

Any references to 'we', 'us' and 'our', refer to Friends Provident International. Friends Provident International is a business name for Friends Provident International Limited.

The information given in this document is based on the understanding of Friends Provident International Limited of current United Arab Emirates and Isle of Man law and taxation practice, as at November 2022, which may change in the future.

No liability can be accepted for any personal tax consequences of this scheme or for the effect of future tax or legislative changes. We do not condone tax evasion and our products and services may not be used for evading your tax liabilities.

All policyholders will receive the protection of the Life Assurance (Compensation of Policyholders) Regulations 1991 of the Isle of Man, wherever their place of residence.

Whilst resident in the United Arab Emirates, complaints we cannot settle can be referred to the United Arab Emirates Insurance Authority or if you wish to the Financial Services Ombudsman Scheme for the Isle of Man.

If you are not resident in the United Arab Emirates or are no longer resident in the United Arab Emirates, complaints we cannot settle can be referred to the Financial Services Ombudsman Scheme for the Isle of Man.

Some telephone communications with the Company are recorded and may be randomly monitored.

LEGAL INTERPRETATION

International Protector Middle East+ is governed by the laws of the United Arab Emirates and all disputes relating to a policy shall be subject to the jurisdiction of the courts of the United Arab Emirates, except as otherwise expressly agreed by the parties in writing.

Friends Provident International Limited: Registered and Head Office: Royal Court, Castletown, Isle of Man, British Isles, IM9 1RA. Isle of Man incorporated company number 11494C. Authorised and regulated by the Isle of Man Financial Services Authority. Provider of life assurance and investment products. **Dubai branch:** PO Box 215113, Emaar Square, Building 6, Floor 5, Dubai, United Arab Emirates. Registered in the United Arab Emirates (UAE) with the Central Bank of the UAE as an insurance company. Registration date, 18 April 2007 (Registration No. 76). Registered with the Ministry of Economy as a foreign company to conduct life assurance and funds accumulation operations (Registration No. 2013). Friends Provident International is a registered trademark and trading name of Friends Provident International Limited.