

# Block Protection Application Form



Irish Life

Application for insurance under permanent tsb GROUP MORTGAGE ASSURANCE plans. This is underwritten by Irish Life  
Please read the questions carefully before answering and use CAPITAL LETTERS throughout.

## Financial adviser's details

Larc registration number  Area  Manager  Code

## A Personal Details<sup>1</sup>

<sup>1</sup> Everyone must fill in this section

### First person to be covered

Mr  Mrs  Miss  Other

First name

Last name

Date of birth  /  /

Marital status    Single     Married   
                          Divorced     Widowed   
                          Separated

Home address<sup>2</sup>

### Second person to be covered

Mr  Mrs  Miss  Other

First name

Last name

Date of birth  /  /

Marital status    Single     Married   
                          Divorced     Widowed   
                          Separated

Home address (if different)<sup>2</sup>

<sup>2</sup> We cannot accept a 'care of' address

Country of birth

Previous surname (if any)

Precise occupation

Current level of earnings    €  each year

Home phone

Work phone

Mobile phone

Email address

Mortgage Number

Country of birth

Previous surname (if any)

Precise occupation

Current level of earnings    €  each year

Home phone

Work phone

Mobile phone

Email address

**THIS FORM TO BE USED AFTER 1 OCTOBER 2004**

## B Life Options Plan

Term of Cover	<input type="text"/>	yrs
	<b>First person</b>	<b>Second person</b>
Amount of Life Cover you want (if any)	€ <input type="text"/>	€ <input type="text"/>
Amount of Specified Illness Cover you want (if any)	€ <input type="text"/>	€ <input type="text"/>
If you have chosen Specified Illness Cover, which type do you want?	Accelerated <sup>3</sup> <input type="checkbox"/>	Accelerated <input type="checkbox"/>
	Independent <sup>4</sup> <input type="checkbox"/>	Independent <input type="checkbox"/>
<sup>3</sup> Accelerated Specified Illness Cover means we reduce your Life Cover by the amount of the specified illness claim and it cannot be greater than the Life Cover.		
<sup>4</sup> Independent Specified Illness Cover means that if you make a specified illness claim, it will not affect any Life Cover. If you choose Life Cover and Specified Illness Cover and do not choose a basis, we will assume the Specified Illness Cover is independent.		
Do you want Contribution Cover ? <sup>5</sup>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<sup>5</sup> We only provide Contribution Cover for the first person.		

## C Life Cash Cover Plan (term assurance)

Term of cover <sup>6,7</sup>	<input type="text"/>	years
<sup>6</sup> The maximum term for Specified Illness Cover is 25 years. If you have chosen a term over 25 years, your Specified Illness Cover will end after 25 years. However your life cover will continue to the end of your chosen term.		
<sup>7</sup> The expiry age for Specified Illness cover is age 65.		
	<b>First person</b>	<b>Second person</b>
Amount of Life Cover you want <sup>8</sup>	€ <input type="text"/>	€ <input type="text"/>
Amount of Specified Illness Cover you want (if any)	€ <input type="text"/>	€ <input type="text"/>
<sup>8</sup> The amount of Specified Illness Cover you choose can not exceed your life cover amount.		
If you have chosen Specified Illness Cover, which type do you want?	Accelerated <input type="checkbox"/>	Accelerated <input type="checkbox"/>
	Independent <input type="checkbox"/>	Independent <input type="checkbox"/>
Do you want Guaranteed Cover again (convertible option)? <sup>9</sup>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<sup>9</sup> You can only take out Guaranteed Cover Again if you are under 55. Guaranteed Cover Again is only available on Specified Illness Cover moved into a unit-linked plan. Subject to a maximum of €500,000 on Special Illness Cover and €1,000,000 on Life Cover.		

## D Life Home Cover (Mortgage Protection)

Term of cover <sup>10,11</sup>	<input type="text"/>	years
<sup>10</sup> The maximum term for Specified Illness cover is 35 years. If you have chosen a term over 35 years, your Specified Illness Cover will end after 35 years. However your life cover will continue to the end of your chosen term. <sup>11</sup> The expiry age for Specified Illness cover is age 75.		
Initial amount of life cover you want	€ <input type="text"/>	
Initial amount of Accelerated Specified Illness Cover you want (if any)? <sup>12</sup>	€ <input type="text"/>	
<sup>12</sup> The amount of Specified Illness Cover you choose can be different to the level of Life Cover but cannot exceed it.		

## F Payment details

Proposed payment amount <sup>13</sup>	€ <input type="text"/>
<sup>13</sup> Irish Life will validate the payment amount for this contract based on personal and plan details and if there is a difference, we will inform you before the plan is issued	

## G Medical and other information

### Important – Telling Irish Life about material facts

Please remember that you must tell us everything relevant when answering all of the questions on the application form. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A material fact (relevant information) includes anything that a reputable insurer would treat as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the section 'Other medical evidence'.

**If your health changes before cover starts, you must let us know immediately.**

### Material facts exemption in relation to genetic tests

We support the view that it is valuable for society to encourage people who have a significant risk of a genetic illness, or who might pass on such a risk to their children, to undergo appropriate and confidential genetic tests under proper medical supervision, including appropriate genetic counselling. Genetic testing in a family can clarify an individual's risk of developing a particular disease. With this in mind and with a view to supporting the practice of preventative medicine, we have put the following exemption in place.

If this application is for Life Cover only and the total amount of Life Cover under:

- (a) this application;
- (b) any other current application to any insurer; and
- (c) any Life Cover amount you already have started with any insurer between 1 May 2001 and 31 December 2005 that is not more than €381,000.

You do not need to tell us about any genetic test (that is, any analysis of chromosomes, DNA, RNA or protein to detect genetic abnormalities in individuals) which you may have had. You must however, tell us if you are having treatment for or are experiencing symptoms of a genetic condition. You must also give us full information about your family history, including all genetic conditions. **(This exemption does not apply if the Life Cover you are applying for is more than the amount set out above or if your application is for cover other than Life Cover.)**

### MEDICAL DETAILS - INSTRUCTIONS

After you have read the note about material facts, please fill in these questions by ticking the boxes marked 'yes' or 'no' (whichever is appropriate). If you answer 'yes' to any questions, please give full details. If you need more space, please fill in the 'other medical evidence' section. Please fill in the Quick Underwriting (supplementary) Medical Questionnaire, if this is appropriate.

	First person to be covered	Second person to be covered
1. Please give the name and address of your doctor.	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
If you have changed doctor in the last year, please give the name and address of your previous doctor as well.	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

### Question 2 need only be asked on applications for LIFE OPTIONS PLAN.

2. Does this application in addition to any other specified illness cover policies you hold exceed €750,000 specified illness cover in total (either in force or currently being processed)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please state amount	<input type="text"/>	<input type="text"/>

### IMPORTANT

3. Please give your height and weight	<input type="text"/> feet <input type="text"/> inches	<input type="text"/> feet <input type="text"/> inches
	<input type="text"/> stones <input type="text"/> lbs	<input type="text"/> stones <input type="text"/> lbs
or alternatively	<input type="text"/> cms <input type="text"/> kilos	<input type="text"/> cms <input type="text"/> kilos
4(a). Have you smoked tobacco of any kind in the past 12 months or do you intend to smoke in the future?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
4(b). If you smoked tobacco of any kind in the last 12 months or you intend to smoke in the future, please fill in the following <sup>14</sup>		
Cigarette Smoker	<input type="text"/> per day	<input type="text"/> per day
Cigar Smoker	<input type="text"/> per day	<input type="text"/> per day
Pipe Smoker	<input type="text"/> Grams per day	<input type="text"/> Grams per day
Do you consume any other form of tobacco.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please supply details	<input type="text"/>	<input type="text"/>

<sup>14</sup> Please include each type of tobacco you consume on a daily basis. A pipe smoker should indicate the number of grams per day. It is our practice to carry out occasional testing to confirm non smoker status.

**First person to be covered**

**Second person to be covered**

5. Please enter your **weekly** consumption of alcohol in units



Please tick if you are a non drinker



Unit Guide: Pint Beer - 2.0 units, Bottle Beer - 1.5 units, Glass beer - 1.0 units, Measure spirits - 1.0 units, Bottle wine - 7.0 units, Glass wine - 1.0 units.

6. Have you ever suffered from or had treatment for heart disorder, stroke, rheumatic fever, high blood pressure or blood disorder?

YES  NO

YES  NO

7. Have you ever suffered from or had treatment for asthma, bronchitis or another lung disorder?

YES  NO

YES  NO

8. Have you ever suffered from or had treatment for multiple sclerosis, numbness, epilepsy, blackouts, paralysis or double vision?

YES  NO

YES  NO

9. Have you ever suffered from or had treatment for kidney or bladder disorder?

YES  NO

YES  NO

10. Have you ever suffered from or had treatment for diabetes or a stomach, liver or bowel disorder?

YES  NO

YES  NO

11. Have you ever suffered from or had treatment for cancer or any other growth or tumour?

YES  NO

YES  NO

12. Have you ever suffered from or had treatment for a mental or nervous disorder?

YES  NO

YES  NO

13. Have you ever suffered from or had treatment for slipped disc, back, arthritic or muscular disorder?

YES  NO

YES  NO

14. Have you ever suffered from or had treatment for disorder of the eyes or ears (other than wearing prescribed glasses or contact lenses)?

YES  NO

YES  NO

15. Have you ever suffered from or had treatment for any other illness, injury or condition for which you have had medical advice in the last five years?

YES  NO

YES  NO

16. Have you had a surgical operation in the last five years?

YES  NO

YES  NO

17. Have you in the last five years had or been advised to have any special investigations, blood or laboratory tests?

YES  NO

YES  NO

18. Are you currently taking prescribed drugs, medicines, tablets or other treatment?

YES  NO

YES  NO

19. Are you currently unwell or receiving medical treatment of any kind, which you have not mentioned in the answers given above?

YES  NO

YES  NO

20. Have you ever taken drugs for other than medical purposes?

YES  NO

YES  NO

21. Have you ever tested positively for HIV or AIDS, Hepatitis B or Hepatitis C or are you waiting for the result of this kind of test?

YES  NO

YES  NO

If YES, please supply details



22. Have you any intention or prospect of taking part in any kind of dangerous activity as a result of your hobbies or pastimes?

YES  NO

YES  NO

If YES, please supply full details.





23. Have you any intention or prospect of living or travelling outside the EU other than for holidays?

YES  NO

YES  NO

If YES, please supply names of countries, reasons for visits and durations of stays.





24. Have you ever applied to Irish Life or any other insurer and been refused, postponed or accepted on special terms for life cover, disability or illness cover?

YES  NO

YES  NO

**First person to be covered**

**Second person to be covered**

25. Have your parents or any of your brothers or sisters suffered or died from heart disease including cardiomyopathy, stroke, kidney disease, cancer, multiple sclerosis, Huntington's chorea, polycystic kidneys, polyposis of the colon or other hereditary disorder before age 60? <sup>15</sup> If your relative had **cancer**, please tell us which part of their body was affected first.

YES  NO

YES  NO

<sup>15</sup> If you are adopted, please answer NO to this question. Cardiomyopathy is a disease affecting the heart muscle. Huntington's chorea is a hereditary disorder which affects the central nervous system. Polycystic kidneys is a disease where cysts develop in the kidneys. Polyposis of the colon is a disease where growths occur in the bowel.

		Condition suffered	Age when it started	Condition suffered	Age when it started
If living	Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
If dead	Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Other medical evidence**

26. If appropriate, you should also fill in the supplementary Quick Underwriting Medical Questionnaire.

**First person to be covered**

Question numbers	Details
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**Second person to be covered**

Question numbers	Details
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

27. Is there a Quick Underwriting Medical Questionnaire (QUQ) or any other questionnaires accompanying the application form?

YES  NO

YES  NO

If YES, please indicate which type of Questionnaire

**H Data Protection**

The information you give here will be used to process your application on computer. We may use this information to send you details of other products from companies within the Irish Life & Permanent group (a financial services group mainly made up of life assurance, banking and personal finance companies). For this purpose we may pass this information to the other companies within the group. If you do not wish to avail of this service, please tick this box.

## I Declaration under regulation 6(3) of the Life Assurance (Provision of Information) Regulations 2001.<sup>16</sup>

<sup>16</sup> All customers must sign and date these declarations.

### Warning

If you propose to take out this plan to totally or partially replace an existing plan, please take special care to make sure that this plan meets your needs. In particular, please make sure that you are aware of the financial consequences of replacing your existing plan. If you are in doubt about this, please contact your insurer or insurance intermediary.

Reference plan number

Please fill in this section by ticking the appropriate box:

This plan does not replace an existing plan.

This plan does replace an existing plan.

If applying for more than one plan, please state the name of the plan(s), if any, which replace an existing plan.

### Declaration of the intermediary

I confirm that in line with regulation 6(1) of the Life Assurance (Provision of Information) Regulations 2001,

has been provided with the information set out in schedule 1 to those regulations and that I have advised the client as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement.

Signature of seller

Date

for

*name of intermediary or insurer*

### Declaration of client

I confirm that I have received, in writing, the information set out in the declaration above.

Signature (1st person to be covered)

Date

Signature (2nd person to be covered)

Date

## J Premium paying arrangements

I agree that all premiums for this insurance cover will be paid to permanent tsb and credited to the applicant(s) Mortgage Account for onward transmission to Irish Life Assurance plc.

I understand that premiums must be paid by the premium due date specified in the Certificate of Membership and failure to pay a premium will result in the insurance cover being cancelled.

## K Declaration

This form is my application to Irish Life for cover under the permanent tsb Group Mortgage Protection Plan. I understand that my contract with Irish Life Assurance plc will be based on this declaration, my application form and any information I give to a medical examiner acting for you. I understand that I must tell Irish Life about any changes in my health or circumstances before this insurance starts.

I have read over the replies to all the questions in this application form and declare that all statements (including any statements written down for me) are true and complete. I have read and understand the notes concerning telling Irish Life about material facts and understand that if I do not tell you all material facts this contract could be void.

I request that the insurance be written as payable to permanent tsb, except that where the proceeds exceeds the amount due to permanent tsb on the loan, any such excess shall be payable to me or the survivor of us or my estate.

I agree that Irish Life may get information from any doctor who at any time has attended me concerning anything which affects my physical or mental health and I authorise them to give Irish Life this information. Irish Life may also get information from any insurance company and I also authorise them to give Irish Life this information. I agree that this authority will stay in force after my death as well as before.

I understand that cover shall not commence until all of the following events have taken place:

- (i) this application for cover has been underwritten and accepted by Irish Life,
- (ii) the drawdown of the mortgage amount as advised by the Proposer, and
- (iii) the first premium has been charged to the mortgage account.

If Irish life turns down an application for insurance or accepts it under special terms Irish Life will note this on a registry administered by the Irish Insurance Federation. Irish Life may share this information with other companies as a protection against not being given material facts.

I authorise Irish Life Assurance plc (ILA) and its agents to hold and process information in connection with this contract or transaction. This includes any other information supplied to or obtained by ILA separately. ILA may hold and process this information for administrative, customer care and service purposes.

Signature of first person to be covered

Date

Signature of second person to be covered (if any)

**PLEASE TAKE TIME TO REVIEW YOUR ANSWERS TO THE QUESTIONS.  
YOU CAN ASK US FOR A COPY OF YOUR FILLED IN APPLICATION FORM.**