Protection Fact Find

Customer(s) Name(s)	

EXISTING PLANS – ***please enter details of any life insurance, Critical Illness Cover (CIC), Income Protection (IP) or Family Income Benefit (FIB) you currently have in place.***

Please add additional pages to record any further existing plans.

	1st Applicant	2nd Applicant
Product type - (life, CIC, Income Protection, Family Income Benefit (FIB)		
Provider		
End Date		
Sum Assured/ Benefit amount		
Premium	£ per month	£ per month
Notes/Description: *(For example: renewal date, Life Assured, Policy number, policy excess, purpose of plan, written in trust & beneficiaries, etc.)*		

Product type - (life, CIC, Income Protection, Family Income Benefit (FIB)		
Provider		
End Date		
Sum Assured/ Benefit amount		
Premium	£ per month	£ per month
Notes/Description: *(For example: renewal date, Life Assured, Policy number, policy excess, purpose of plan, written in trust & beneficiaries, etc.)*		

INSURANCE COVER REQUIRED	1st Applicant	2nd Applicant
If you or your partner dies, is it important that you protect against the financial consequences of death?	Yes ☐ No ☐	Yes ☐ No ☐
If you or your partner were to suffer a critical illness or permanent disability, is it important to protect against the financial consequences of these events?	Yes ☐ No ☐	Yes ☐ No ☐
If you or your partner were unable to work in the long term (2 years+) due to illness or accident, is it important to you to be able to pay your mortgage and other bills?	Yes ☐ No ☐	Yes ☐ No ☐
If you or your partner were unable to work in the short term (1- 2 years) due to illness, accident or unemployment, is it important to you to be able to pay your mortgage and other bills?	Yes ☐ No ☐	Yes ☐ No ☐
Notes:		

EMPLOYER BENEFITS	1st Applicant	2nd Applicant
Life Cover	£	£
Critical Illness Cover	£	£
Income Protection	£	£
Workplace Pension Death Benefits	£	£
In the event of long term sickness:		
How much income will you receive?	£	£
For how long?	(months)	(months)
Deferred Periods: (*Confirm waiting periods for any benefits to be paid*)		
Do you wish to include employer benefits as part of any shortfall calculations?	Yes ☐ No ☐	Yes ☐ No ☐
Comments: *(You should discuss the implications of relying on employer benefits and the potential consequences of moving/losing employment)*		
Notes:		

Honest and truthful disclosure

You must answer all questions truthfully and honestly even if this has been provided on a previous application through iMAB.

HEALTH & LIFESTYLE	1st Applicant		2nd Applicant	
How would you describe your health?	Good	☐	Good	☐
	Average	☐	Average	☐
	Poor	☐	Poor	☐
Smoker status (including nicotine gum, vaping & patches)?	Choose an item.		Choose an item.	
If you currently smoke, how many cigarettes do you smoke on average per day?				
On average, how frequently do you drink alcohol?	Daily Weekly Monthly Special occasions only Not at all		Daily Weekly Monthly Special occasions only Not at all	
When you do drink alcohol, how many drinks will you have over the period specified above?				
How tall are you?	ft or m	ins	Ft or m	ins
How much do you weigh?	st or kg	lbs	st or kg	lbs
Waist size (male) or dress size (female)				
Have you EVER sufferered from: Cancer, carcinoma-in-situ or any other tumour? Including: Any lump, cyst or tumour in your brain or spine, Lymphoma, Hodgkin's or Non-Hodgkin's lymphoma, Leukaemia, cancer in situ.	Yes ☐ No ☐		Yes ☐ No ☐	
Anything affecting your heart or arteries or surgery on your heart or arteries? Including: Angina or heart attack, angioplasty, stent or bypass, irregular heart beat or palpitations, heart murmur, heart valve or heart structure abnormalities, peripheral vascular disease, cardiomyopathy or heart enlargement.	Yes ☐ No ☐		Yes ☐ No ☐	

A stroke, TIA, brain haemorrhage or damage or surgery to your brain? Including: Mini stroke or transient ischaemic attack (TIA), cerebral aneurysm.	Yes ☐ No ☐	Yes ☐ No ☐
Multiple sclerosis, epilepsy, Parkinson's disease or any other neurological symptoms or condition? Including: Alzheimer's, dementia, motor neurone disease, muscular dystrophy, cerebral palsy, paralysis.	Yes ☐ No ☐	Yes ☐ No ☐
A positive test for HIV/AIDS or hepatitis B or C, or are you waiting for the test results for one of these conditions? If you're waiting for a test result that turns out to be negative, this will not affect the decision to offer you cover.	Yes ☐ No ☐	Yes ☐ No ☐
In the last 5 years, regardless of whether you've seen a doctor, required treatment or had time off work, have you had: Diabetes, raised blood sugar levels or sugar in your urine?	Yes ☐ No ☐	Yes ☐ No ☐
Anaemia, blood clot or any other blood disorder? Including: Thrombosis or blood clotting issues.	Yes ☐ No ☐	Yes ☐ No ☐
A growth, lump, cyst or polyp? Including: A lesion, or a mole or freckle that has bled become painful or changed appearance.	Yes ☐ No ☐	Yes ☐ No ☐
Crohn's, colitis, IBS, or anything else affecting your stomach, bowel or digestive system? Including: Irritable bowel syndrome (IBS), Barrett's oesophagus, ulcers or bleeding. The digestive system includes your gullet (oesophagus), stomach, duodenum and intestines.	Yes ☐ No ☐	Yes ☐ No ☐
Only needed for males: Kidney stones, urinary infection or anything else affecting your kidneys, prostate, bladder or urine? Including: Polycystic kidney disease, blood or protein in your urine, raised PSA (prostate-specific antigen), bladder stones.	Yes ☐ No ☐	Yes ☐ No ☐
Only needed for females: Kidney stones, urinary infection or anything else affecting your kidneys, bladder or urine? Including: Polycystic kidney disease, blood or protein in your urine, bladder stones.	Yes ☐ No ☐	Yes ☐ No ☐
Only needed for females: An abnormal cervical smear, or any other gynaecological disorder that has required follow-up, or an abnormal mammogram? Including: Fibroids, Endometriosis, Polycystic ovarian syndrome	Yes ☐ No ☐	Yes ☐ No ☐
Anything affecting your liver or pancreas? Including: Hepatitis, jaundice, an abnormal blood test or scan of your liver.	Yes ☐ No ☐	Yes ☐ No ☐
Back pain, sciatica, whiplash or anything else affecting your back or neck? Including:	Yes ☐ No ☐	Yes ☐ No ☐

Trapped nerves or muscular back or neck ache.		
Joint or muscle pain, any type of arthritis, gout or anything else affecting your bones, joints, muscles or limbs? Including: Ligament, tendon and muscle injuries, carpal tunnel syndrome, repetitive strain injuries, fractures.	Yes ☐ No ☐	Yes ☐ No ☐
Numbness, pins and needles, muscle weakness, fainting, migraine, tremor or difficulty with coordination? Including: Tingling, facial pain, blackouts.	Yes ☐ No ☐	Yes ☐ No ☐
Tinnitus, labyrinthitis, or anything else affecting your ears, hearing or balance? Including: Deafness, Meniere's disease, balance problems or dizziness.	Yes ☐ No ☐	Yes ☐ No ☐
Impaired, blurred or double vision, optic neuritis or anything else affecting your eyes or vision?	Yes ☐ No ☐	Yes ☐ No ☐
Chronic fatigue syndrome (CFS), Myalgic Encephalomyelitis (ME), fatigue, fibromyalgia or persistent tiredness?	Yes ☐ No ☐	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐	Yes ☐ No ☐
Stress	Yes ☐ No ☐	Yes ☐ No ☐
Depression	Yes ☐ No ☐	Yes ☐ No ☐
Suicide attempts/thoughts	Yes ☐ No ☐	Yes ☐ No ☐
Asthma, bronchitis, sleep apnoea, or anything else affecting your lungs or breathing? Including: Chronic obstructive pulmonary disease (COPD), Emphysema You don't need to tell us about: Common colds or flu, one-off chest infections that you have fully recovered from.	Yes ☐ No ☐	Yes ☐ No ☐
Raised blood pressure or cholesterol, or chest pain?	Yes ☐ No ☐	Yes ☐ No ☐
Are you awaiting any outstanding tests, investigations or the results of either? If "Yes": What for? When due?	Yes ☐ No ☐	Yes ☐ No ☐
Are there any conditions you have consulted a doctor about other than minor coughs and colds in the last 5 years or that you need to see your GP about	Yes ☐ No ☐	Yes ☐ No ☐
Do you take any medication? If Yes,please answer: What medication? For what condition/symptom? How often?	Yes ☐ No ☐	Yes ☐ No ☐
Have any of your natural parents, brothers or sisters, suffered from any of the following before the age of 65: Breast Cancer	Yes ☐ No ☐	Yes ☐ No ☐
Bowel Cancer	Yes ☐ No ☐	Yes ☐ No ☐
Ovarian Cancer	Yes ☐ No ☐	Yes ☐ No ☐

Cancer – other (please specify)	Yes ☐ No ☐	Yes ☐ No ☐
Heart attack or heart condition	Yes ☐ No ☐	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Yes ☐ No ☐
MS	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Yes ☐ No ☐
Alzheimers	Yes ☐ No ☐	Yes ☐ No ☐
Parkinsons	Yes ☐ No ☐	Yes ☐ No ☐
Motor Neurones	Yes ☐ No ☐	Yes ☐ No ☐
If "Yes", please answer: Which condition? Which relative? What age diagnosed?		
Have you ever had a protection application loaded (increased premium) or declined?	Yes ☐ No ☐	Yes ☐ No ☐
Do you participate in any Hazardous Pursuits such as flying, diving, climbing or motorsports?	Yes ☐ No ☐	Yes ☐ No ☐
Are any elements of your job hazardous?		
Offshore Worker?	Yes ☐ No ☐	Yes ☐ No ☐
Driver?	Yes ☐ No ☐	Yes ☐ No ☐
Work at heights (over 40ft)	Yes ☐ No ☐	Yes ☐ No ☐
Hazardous duties	Yes ☐ No ☐	Yes ☐ No ☐
What percentage of your work is manual?	%	%
Notes: *(confirm details of any existing or hereditary conditions; current medication or treatment; hazardous pursuits or employment)*		
If yes to any of the questions above, please provide further details: When diagnosed (date) Last symptoms (date) Treatment Any ongoing medication Readings/stages Did you have any time off work? If so, how long?		

COVID-19 SPECIFIC	**1st Applicant**	**2nd Applicant**
In the last 30 days have you tested positive for or been diagnosed with coronavirus or COVID-19?	Yes ☐ No ☐	Yes ☐ No ☐
In the last 30 days have you had a new or unexplained continuous cough, fever, high temperature, loss of smell or taste?	Yes ☐ No ☐	Yes ☐ No ☐
In the last 14 days, have you been self-isolating or been advised you should? Please answer no if you are following general social-distancing advice to avoid spread of the virus or working from home due to workplace advice only	Yes ☐ No ☐	Yes ☐ No ☐
In the last 14 days, have you had direct contact with someone who has been diagnosed with, or suspected of having coronavirus or COVID-19	Yes ☐ No ☐	Yes ☐ No ☐

GP surgery (name and address)		

Doctors name		

DECLARATION

I/We agree that this Fact Find is a true record of my/our discussions with our adviser and that this information is true to the best of my/our knowledge.

I/We accept that this Fact Find relates only to advice given in connection with my/our insurance needs.

Applicant 1's signature		Date	Click here to enter a date.

Applicant 2's signature		Date	Click here to enter a date.