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**Protection Fact Find**

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| Customer(s) Name(s) |  |
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**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.*

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|  | **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.)* |

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| Product type - (life, CIC, Income Protection, Family Income Benefit (FIB) |  |  |
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| 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.)* |

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| **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:** |

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| **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.

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| **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? |  |  |
| How tall are you? | ftor m | ins | Ftor m | ins |
| How much do you weigh? | stor kg | lbs | stor kg | lbs |
| Waist size (male) or dress size (female) |  |  |
| Have you EVER sufferered from:Cancer | Yes [ ]  No [ ]  | Yes [ ]  No [ ]  |
| Heart Attack |  Yes [ ]  No [ ]  | Yes [ ]  No [ ]  |
| Stroke | Yes [ ]  No [ ]  | Yes [ ]  No [ ]  |
| Multiple-Sclerosis | Yes [ ]  No [ ]  | Yes [ ]  No [ ]  |
| Diabetes | 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 | Yes [ ]  No [ ]  | Yes [ ]  No [ ]  |
| High Blood Pressure | Yes [ ]  No [ ]  |  Yes [ ]  No [ ]  |
| High Cholesterol | Yes [ ]  No [ ]  | Yes [ ]  No [ ]  |
| If yes, please provide further details:When diagnosed (date)Last symptoms (date)TreatmentAny ongoing medicationReadings/stagesDid you have any time off work? If so, how long? |
| 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 [ ]  |
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| Have you |  |  |
| 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)* |

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| **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 [ ]  |

**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.

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

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