PROTECTION PRODUCTS
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To obtain an illustration please ensure you complete all sections of this form. We will require Terms of Business to proceed beyond illustration.

ABI GENETIC TESTING CODE OF PRACTICE

You may need to tell Partnership about certain genetic test results when applying for life insurance if, after an illustration, you proceed to an application, and the total amount taken together with any other life assurance policies exceeds £500,000. If you think this may apply to you, please ask Partnership for details of their current position. These details are also available from the ABI website at **abi.org.uk/products-and-issues/topics-and-issues/genetics/genetic-testing/**

The adviser should direct these questions to the applicant.

SECTION 1: CLIENT DETAILS

	First life	Second life
Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other
If 'other' please specify		
Forename(s)		
Surname		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth	DD-MM-YYYY	DD-MM-YYYY
UK resident	☐ Yes ☐ No	☐ Yes ☐ No
Height	ft ins or cms	ft ins or cms
Weight	st lbs or kgs	st lbs or kgs
Drinks alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
How many units of alcohol do you drink weekly? (Required if drinks alcohol)	Units	Units
Have you been advised by a member of the medical profession to reduce your alcohol intake? (Required if drinks alcohol)	☐ Yes ☐ No	☐ Yes ☐ No
Have you smoked or used any tobacco or nicotine products, including e-cigarettes, in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
Tobacco/nicotine type*		
Number/weight per week*		
*Required if answered yes to tobacco, nicotine or e-cigarettes		
Occupation		
Are you unable to work for medical reasons?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please provide details on 'additional notes' page 5

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SECTION 2: POLICY DETAILS

Type of life insurance required (Tick as appropriate. Please note our product range does not include either critical illness or waiver of premium.)

	Level Term Assurance ☐	Decreasing Term Assurance ☐	Whole of Life ☐	Family Income Benefit ☐	Gift Inter Vivos ☐
Terminal Illness option*	Included	Included	☐ Yes ☐ No	Included	N/A
Sum assured/annual income	£	£	£	£	£
or specific premium amount	£	£	£	£	£
Plan term (years)	☐ (2-50)	☐ (2-50)		☐ (10-50)	7
Joint life	☐	☐	☐	☐	
or					
Single Life *(please indicate which life assured)*	☐ First ☐ Second	☐ First ☐ Second	☐ First ☐ Second	☐ First ☐ Second	☐ First
Payment Frequency	☐ Monthly ☐ Annually	☐ Monthly ☐ Annually	☐ Monthly ☐ Annually ☐ Single	☐ Monthly ☐ Annually	✓ Single

SECTION 3: PREVIOUS COVER

	First life	Second life
Have any applications or enquiries for life cover been declined or postponed?	☐ Yes ☐ No	☐ Yes ☐ No
Date declined/postponed	☐☐ ☐☐ ☐☐☐☐ DD-MM-YYYY	☐☐ ☐☐ ☐☐☐☐ DD-MM-YYYY
If declined, Insurer declined by		
Reason if known		
If postponed, how long for		
Insurer postponed by		
Reason if known		

*Terminal illness Cover (TIC) is an option under the Whole of Life plan. TIC is automatically included in Level Term Assurance, Decreasing Term Assurance and Family Income Benefit. TIC is not included in policies written under a Gift Inter Vivos Trust

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SECTION 4: RESIDENCE AND TRAVEL

	First life	Second life
Do you intend to live, work or travel abroad other than for holidays?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please give details of country, duration and reason		

SECTION 5: HAZARDOUS ACTIVITIES

	First life	Second life
Do you take part in any hazardous sports/pastimes?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please provide details		
If you work at heights, underground, underwater, offshore, with explosives or in the armed forces please provide full details		

SECTION 6: FAMILY HISTORY

	First life	Second life
Have your parents, brothers or sisters, before age 65, died or suffered from heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, multiple sclerosis, paralysis or any hereditary disorder?	☐ Yes ☐ No	☐ Yes ☐ No
Please indicate the age of the relative when they first suffered the condition and details of the condition itself including, for cancer, the part of the body affected		

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SECTION 7: HEALTH CONDITIONS

Please complete for all conditions continuing in additional notes section if necessary.

	First life	Second life
1. Name of condition, illness or injury		
Date diagnosed	DD-MM-YYYY	DD-MM-YYYY
Treatments/investigations. Include dates, severity, ongoing symptoms, any complications and, if applicable, latest blood pressure/cholesterol readings/cancer type and staging		
Medication, including quantity		
2. Name of condition, illness or injury		
Date diagnosed	DD-MM-YYYY	DD-MM-YYYY
Treatments/investigations. Include dates, severity, ongoing symptoms, any complications and, if applicable, latest blood pressure/cholesterol readings/cancer type and staging		
Medication, including quantity		
3. Name of condition, illness or injury		
Date diagnosed	DD-MM-YYYY	DD-MM-YYYY
Treatments/investigations. Include dates, severity, ongoing symptoms, any complications and, if applicable, latest blood pressure/cholesterol readings/cancer type and staging		
Medication, including quantity		

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SECTION 8: FINANCIAL ADVISER DETAILS

Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other If 'other' please specify
Forename(s)	
Surname	
Network	
Firm	
FCA number	
Address	
Postcode	
Telephone number	ext:
Email	

By submitting this form I confirm that I have shown the Privacy Notice on page 6 to my client and I have their explicit consent to share their data with Partnership and for it to be used as detailed within the Notice.

ADDITIONAL NOTES

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PRIVACY NOTICE

We take collection and management of your personal data very seriously.

This notice explains how the information held by Partnership Life Assurance Company Limited (referred to as "**Partnership**", "**we**" or "**us**" throughout this notice) will be treated.

How your information will be used

The information collected shall be processed in accordance with the Data Protection Act 1998 ("the **Act**") and any successor legislation. All references to "**Personal Data**", "**Sensitive Personal Data**" "**Data Subject**" and "**Processing**" shall have the same meaning as set out in the **Act**.

References to "your information" and "your personal data" shall mean **Personal Data** and/or **Sensitive Personal Data** (such as medical data), that is disclosed to **us**, for which an identifiable individual (**Data Subject**) is the focus.

The information provided to **us** may be used:

To provide any requested product or service and to deal with any enquiries and requests **we** may receive;

- To underwrite and administer a **Partnership** product;
- For research and statistical analysis; and
- For the purposes of complying with applicable legal and regulatory obligations.

If personal information is submitted about another person, then by signing this form you confirm that they have consented to providing their information to **Partnership** and for the information to be used and shared as set out in this notice.

Sharing Personal Data

Where necessary and only for the purposes mentioned above, information (including your medical data) may be shared with:

- Other companies within the group of **Partnership** companies and any future owners of our business and/or affiliates;
- Service providers of **Partnership**, such as reinsurers, third party administrators, professional advisors, tracing agencies and/or research companies;
- Doctors or any relevant medical professional;
- With credit reference agencies (for the purposes of identity verification);
- Agencies or third parties for the purposes of preventing, detecting or investigating financial crime; and/or
- Regulators or such other authority if required to do so by law or by any court order or if **Partnership** has consent to do so.

The information provided in this form will be held securely and will not be held for longer than is necessary.

There may be a scenario where the information could be processed outside of the European Economic Area (EEA). In this situation **we** confirm that only the minimum amount of data will be processed, and appropriate security measures in accordance with the **Act** will be applied.

Further Information

The **Act** provides individuals (**Data Subjects**) with various rights including the right to be told what **Personal Data** is held by **Partnership** and the right to request that any inaccuracies in respect of their **Personal Data** are corrected.

Should there be any queries regarding **Personal Data** or individuals rights under the **Act**, please contact **Partnership's Data Protection Officer** in writing at:

Partnership
Vale House
Bancroft Road
Reigate
Surrey
RH2 7RU

partnership

Regent House, 1-3 Queensway, Redhill, Surrey RH1 1QT

0333 043 7040*

info@partnership.co.uk

www.partnership.co.uk

*Telephone calls may be recorded for training and monitoring purposes. Local call rates apply.

If you require this document in an alternative format please contact us.

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