



Application Form

International Term Assurance



FRIENDS PROVIDENT
INTERNATIONAL

IMPORTANT INFORMATION

Part 1 – Introduction – It is most important that you read this Part before completing the application form.

- 1 If you have signed this Application in the United Kingdom you should have received a 'Key Features Leaflet' and an illustration for this Plan. Please speak to your Financial Adviser if you have not already received this.

Please read all of this form and contact your Financial Adviser if there are any questions that are unclear.

Please use BLOCK CAPITALS throughout and tick the boxes where appropriate.

If you make a mistake please cross it out, put in the correct word or words and initial next to the correction.

If you need more space to write your answers, please use the section headed 'Additional Information' in Part 11.

- 2 Help us to assess your Application fairly by telling us all the information that may affect our decision to insure you. **If you are uncertain about whether any particular fact would influence our decision, you should include it. If you do not, Friends Provident International will be legally entitled to not pay a claim and to cancel your policy.**

IF ANYTHING ABOUT YOUR HEALTH OR CIRCUMSTANCES CHANGES AFTER YOU HAVE COMPLETED THIS APPLICATION AND BEFORE WE ASSUME RISK FOR 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.

Changes would include having or expecting to have doctor, hospital or clinic consultations, treatment as an in-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.

If you would prefer, you may complete the medical questions in private and return the Application Form direct to the Chief Medical Officer. Please indicate on this form if you have done so.

- 3 The Plan will not start until we have assessed and accepted your application, and the first premium has been paid. If you have a full or half birthday while your application is being processed, the terms may differ from those originally quoted.

In most instances your payments will be as originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms.

- 4 To qualify for 'non smoker' status rates you must not have used any form of tobacco or nicotine products within the last twelve months.

We reserve the right to check the accuracy of your reply if you have indicated on this application that you do not use any form of tobacco or nicotine products.

- 5 We may ask you to contact your doctor if we are waiting for reports, which we have asked for.

If we ask you to attend a medical examination, we will need to share the application information with any company we authorise to conduct such examinations. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered. Or, we may need to send them at a later stage for purposes relating to managing the policy. You can get details of general reinsurance principles and details of any company we use to assess your application, from our head office.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

- 6 You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Part 2 – Plan details

Required currency (please tick) GBP USD EUR All payments must be made in the currency chosen. Benefits will also be paid out in this currency.

How long do you want your Plan to run? years Minimum term 5 years for monthly premiums
1 year for annual premiums
Maximum term 35 years or to age 80 next birthday

Please complete **EITHER**

Amount of life cover you require Minimum life cover GBP10,000
USD17,500
EUR15,000

OR

Amount of premium Minimum payment GBP10.00 monthly 100.00 annually
USD17.50 175.00
EUR15.00 150.00

Payable Monthly Annually

Method of payment *Charge Card *Direct Debit

* Please complete the appropriate authority in Part 15

Trust Facilities

Is the Plan to be written under Trust from outset? Yes

A fully completed trust form is required before the policy may commence.
If left blank, we will assume that you do not require the Plan to be written under Trust.

If 'Yes', is/are the planholder(s) and/or trustee(s) resident in the UK? Yes No

Part 3 – Reason for plan

- 1 a) Is this plan to be in conjunction with your mortgage? Yes No
- b) Is there anyone else involved in this mortgage who is not applying for this Plan? Yes No

If 'Yes', please state their name and your relationship to them

Name	Relationship
<input type="text"/>	<input type="text"/>

2 a) Reason for plan if not mortgage related

b) How did you arrive at the amount of cover requested?

FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Part 4 – Personal details

The Life (Lives) Assured is (are) the person(s) on whose Life (Lives) the policy is to be written.

	First (or only) Life	Second Life
1 Title eg Mr, Mrs, Dr	<input type="text"/>	<input type="text"/>
2 Last name (or surname)	<input type="text"/>	<input type="text"/>
3 First name(s)	<input type="text"/>	<input type="text"/>
4 Current residential address (including street name, town and area code if known)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
5 Telephone number(s)	Work <input type="text"/> Home <input type="text"/>	Work <input type="text"/> Home <input type="text"/>
6 E-mail address(es)	<input type="text"/>	<input type="text"/>
7 ID number (if applicable)	<input type="text"/>	<input type="text"/>
8 Date of birth	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year Minimum age 19 next birthday Maximum age 75 next birthday	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year Minimum age 19 next birthday Maximum age 75 next birthday
9 Marital status	<input type="text"/>	<input type="text"/>
10 Relationship or nature of interest between the two lives to be Assured	<input type="text"/>	<input type="text"/>
11 What is your height?	<input type="text"/> ft <input type="text"/> ins or <input type="text"/> cm	<input type="text"/> ft <input type="text"/> ins or <input type="text"/> cm
12 a) What is your weight?	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg
b) Have you recently lost or gained any weight?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please give details.	Details <input type="text"/>	Details <input type="text"/>
13 a) Name and address of your doctor.	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Please note we may not contact your doctor. Even if we do, you must still disclose all the material facts when completing this application.		
	Telephone <input type="text"/>	Telephone <input type="text"/>
	Fax <input type="text"/>	Fax <input type="text"/>
b) How long has your doctor known you?	<input type="text"/> years	<input type="text"/> years
c) When did you last attend your doctor?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
d) Name(s) and address(es) (including telephone and fax numbers) of any other doctor(s) you have consulted in the last five years	<input type="text"/>	<input type="text"/>

FRIENDS PROVIDENT WILL ONLY PAY FOR MEDICAL INFORMATION WHICH IT HAS SPECIFICALLY REQUESTED.

Part 5 – Occupation

	First (or only) Life	Second Life
1 Occupation	<input type="text"/>	<input type="text"/>
2 Annual earned income (state currency used)	<input type="text"/>	<input type="text"/>
3 Nature of employer's business	<input type="text"/>	<input type="text"/>
4 Please give details if you work underground, underwater, at heights over 10 feet/3 metres, offshore or of any other hazardous aspects of your occupation	<input type="text"/>	<input type="text"/>

Part 6 – Residential and travel details

	First (or only) Life	Second Life
1 Nationality (evidence may be required)	<input type="text"/>	<input type="text"/>
2 Town & country of birth	<input type="text"/>	<input type="text"/>
3 Country of permanent residence (if different to country of birth or current residence)	<input type="text"/>	<input type="text"/>
4 Details of your current residential status (include length of stay granted by visas etc and whether right of permanent residence has been granted)	<input type="text"/>	<input type="text"/>

First (or only) Life

5 a) Details of your residence and travel during the last five years (other than holidays)

Dates of stay	Country	Frequency (number of trips per year)	Duration of each stay
<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"/>	<input type="text"/>	<input type="text"/>

5 b) Details of your future residence/travel intentions (other than holidays)

Dates of stay	Country	Frequency (number of trips per year)	Duration of each stay
<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"/>	<input type="text"/>	<input type="text"/>

Second Life

6 a) Details of your residence and travel during the last five years (other than holidays)

Dates of stay	Country	Frequency (number of trips per year)	Duration of each stay
<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"/>	<input type="text"/>	<input type="text"/>

6 b) Details of your future residence/travel intentions (other than holidays)

Dates of stay	Country	Frequency (number of trips per year)	Duration of each stay
<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"/>	<input type="text"/>	<input type="text"/>

Part 7 – Recreation details

	First (or only) Life	Second Life
<p>1 Have you used any form of tobacco or nicotine products (eg patches, gum etc) in the last 12 months?</p> <p>If Yes, please state what form and how much a day.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><input type="text"/> per day</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><input type="text"/> per day</p>
<p>2 How much alcohol do you drink?</p> <p>(1 unit = a single measure of spirits or 1 glass of wine or ½ pint of beer.)</p>	<p>Units per week <input type="text"/></p>	<p>Units per week <input type="text"/></p>
<p>3 Have you ever taken recreational drugs (eg Ecstasy, cocaine, heroin)?</p> <p>If Yes, please provide full details.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details <input type="text"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details <input type="text"/></p>
<p>4 Have you ever suffered from alcohol or drug abuse or been advised by a doctor to reduce or stop your alcohol consumption on medical grounds?</p> <p>If Yes, please provide full details.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details <input type="text"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details <input type="text"/></p>
<p>5 Do you take part in any hazardous sports or pastimes or do you intend to start? (Mountaineering, motor sports, horseriding, skiing and private flying are examples but you should include any activity that is hazardous).</p> <p>If Yes, please provide full details.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details <input type="text"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details <input type="text"/></p>

Part 8 – Insurance history

	First (or only) Life	Second Life
<p>1 Have you applied to any other company for life insurance, or insurance against 'critical illness' in the last 12 months or are you about to do so?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Company <input type="text"/></p> <p>Details <input type="text"/></p> <p>Date <input type="text"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Company <input type="text"/></p> <p>Details <input type="text"/></p> <p>Date <input type="text"/></p>
<p>2 Have you ever applied for life insurance, 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?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Company <input type="text"/></p> <p>Details <input type="text"/></p> <p>Date <input type="text"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Company <input type="text"/></p> <p>Details <input type="text"/></p> <p>Date <input type="text"/></p>

Part 9 – Family history

1 First (or only) Life

Before the age of 60, did either of your parents or any of your brothers or sisters suffer or die from heart disease, diabetes, cancer, multiple sclerosis, Huntington’s disease, polycystic kidney disease, polyposis of the colon or any other hereditary disorder?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If Yes, please fill in the sections below for relatives who are or were affected by the illnesses shown. **Please give the age when they began.** If your relative had cancer, please tell us which part of the body **was first affected**.

	Living		Dead	
	Current age	Medical conditions past and present. Please state age at onset.	Cause of death	Age at death
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"/>

2 Second Life

Before the age of 60, did either of your parents or any of your brothers or sisters suffer or die from heart disease, diabetes, cancer, multiple sclerosis, Huntington’s disease, polycystic kidney disease, polyposis of the colon or any other hereditary disorder?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If Yes, please fill in the sections below for relatives who are or were affected by the illnesses shown. **Please give the age when they began.** If your relative had cancer, please tell us which part of the body **was first affected**.

	Living		Dead	
	Current age	Medical conditions past and present. Please state age at onset.	Cause of death	Age at death
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"/>

Part 10 – Health questions

Please answer each of the following questions ticking boxes where appropriate.

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

If you are in any doubt as to whether any fact is material, you should disclose it. If you do not, Friends Provident International will be legally entitled to not pay a claim and to cancel your policy(ies).

Friends Provident International adheres to the Association of British Insurers' (ABI) policy on genetics and insurance. In accordance with the Association of British Insurers' (ABI) policy on genetics and insurance, you do not need to tell us about any genetic test result you have had if this Application for insurance, taken together with any other insurance policies you already have, for this type of insurance, totals:

- £500,000 (or USD/EUR equivalent) or less for Life Insurance;

Above these limits, you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the UK Government’s Genetics and Insurance Committee (GAIC) has approved them for insurers to use. If you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at www.abi.org.uk/consumer2/disclosure.htm.

However, you must tell us if you either have a family history of, have or are experiencing symptoms of, or have had or are having treatment for, a medical condition including any genetically inherited condition.

If you wish to disclose to us a negative genetic test result, which shows us that you have not inherited a genetic disorder, we will take this into account in setting your premium, providing your clinical geneticist confirms that this test result indicates a reduced risk of developing the inherited disease.

First (or only) Life

Second Life

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

a) Cancer, leukaemia, Hodgkin’s disease, lymphoma, brain or spinal tumour?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Heart disease (including heart attack, angina, heart defects from birth or heart surgery)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) Stroke, brain haemorrhage or brain injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) Multiple sclerosis, Parkinson’s disease, paralysis, epilepsy, Alzheimer’s disease, dementia or cerebral palsy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e) Any other disorder of the central nervous system not already mentioned?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) Disease or disorder of the arteries (including disease in the legs or of the aorta)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g) Diabetes or sugar in the urine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
h) Mental illness that has required hospital treatment or referral to a psychiatrist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
i) A positive test for HIV/AIDS or are you awaiting the result of any such test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered ‘Yes’ to any part of question 1, please give details on the next page, including disorders, dates, duration of illness, treatment, results of investigations and tests and time off work.

Part 10 – Health questions (continued)

	First (or only) Life	Second Life
Disorder(s)	<input type="text"/>	<input type="text"/>
Date of disorder(s) and duration	<input type="text"/>	<input type="text"/>
Treatment	<input type="text"/>	<input type="text"/>
Results of investigations	<input type="text"/>	<input type="text"/>
Time off work and when	<input type="text"/>	<input type="text"/>

	First (or only) Life	Second Life
2 In the last 5 years have you had any of the following:		
a) Any lump or growth, or mole or freckle that has bled, caused pain or changed appearance?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Asthma, bronchitis or any other respiratory disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Numbness, loss of feeling or tingling of the limbs or face, loss of balance or coordination?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Seizures, fits, fainting or blackouts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Any disorder of the eyes or ears including blurred or double vision, or impaired hearing? (You can ignore sight problems corrected by glasses or contact lenses).	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Arthritis, back pain, sciatica, neck, knee or wrist pain?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Any other disorder of the joints, bones or muscles (including RSI)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, hepatitis, colitis or Crohn's disease)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Any blood disorder or anaemia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) Thyroid disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
l) Disorder of the kidney, bladder or the genito-urinary system (including blood or protein in the urine and urinary tract infections)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
m) Depression, anxiety, stress, fatigue or nervous breakdown?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Part 10 – Health questions (continued)

	First (or only) Life		Second Life	
n) Medical investigation, scan or test or have you been advised to have such investigations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
o) Attendance at a hospital as an inpatient or as an outpatient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
p) A surgical operation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered 'Yes' to any part of question 2, please give details below, including disorders, dates, duration of illness, treatment, results of investigations and tests and time off work.

	First (or only) Life	Second Life
Disorder(s)	<input type="text"/>	<input type="text"/>
Date of disorder(s) and duration	<input type="text"/>	<input type="text"/>
Treatment	<input type="text"/>	<input type="text"/>
Results of investigations	<input type="text"/>	<input type="text"/>
Time off work and when	<input type="text"/>	<input type="text"/>

3 In the next 12 months:

Are you due to have any check-up in connection with any medical conditions or are you waiting for the result of any medical investigations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If you answered 'Yes' to this question, please give details below.

	First (or only) Life	Second Life
Medical condition	<input type="text"/>	<input type="text"/>
Date of check up/medical investigation	<input type="text"/>	<input type="text"/>

Part 10 – Health questions (continued)

	First (or only) Life	Second Life
4 In the last 12 months:		
a) Have you had any medical consultation (eg with a doctor, consultant, psychiatrist, hospital, clinic, osteopath etc)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>You do not need to give details of occasional consultations with your GP for just colds, flu, and for consultations for oral contraceptive pills, smear tests, well man/woman check ups and where the results are known and were normal.</i>		
b) Have you been prescribed drugs, medicines or tablets or had any other form of medical treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered 'Yes' to any part of question 4, please give details below, including disorders, dates, duration of illness, treatment, results of investigations and tests and time off work.

If you need more space, please use Part 11.

	First (or only) Life	Second Life
Disorder(s)		
Date of disorder(s) and duration		
Treatment		
Results of investigations		
Time off work and when		

<p>5 Have you ever belonged to or have you ever been a sexual partner of any of the following groups: homosexual men, bisexual men, intravenous drug users, someone known to be HIV positive, someone whose normal area of residence is or was Africa or Asia?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details		Details

<p>6 Have you ever undergone any surgical procedure outside the United Kingdom or been a recipient of blood products outside the United Kingdom?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details		Details

Part 11 – Additional Information

First (or only) Life

Second Life

Part 12 – Applicant(s) details

Only complete this section if the person(s) named in Part 4 are not to be the applicants, or if a company or trust is to own the plan.

	First (or only) Person	Second Person
1 Title (please tick)	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other Please Specify <input type="text"/>	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other Please Specify <input type="text"/>
2 Last name (or surname)/company or trust name	<input type="text"/>	<input type="text"/>
3 First name(s)	<input type="text"/>	<input type="text"/>
4 Current residential address (including street name, town and area code if known)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
5 Telephone number(s)	Work <input type="text"/> Home <input type="text"/>	Work <input type="text"/> Home <input type="text"/>
6 E-mail address(es)	<input type="text"/>	<input type="text"/>
7 ID number (if applicable)	<input type="text"/>	<input type="text"/>
8 Date of birth (if applicable)	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
9 Marital status (if applicable)	<input type="text"/>	<input type="text"/>
10 Nationality (if applicable)	<input type="text"/>	<input type="text"/>
11 Country of birth (if applicable)	<input type="text"/>	<input type="text"/>
12 Country of permanent residence (if different to above) (if applicable)	<input type="text"/>	<input type="text"/>
13 What is your relationship or interest in the person(s) named in Part 4?	<input type="text"/>	

Correspondence Address

All communications will be sent to the address of the first Plan owner. If you do not wish this to be the case, please provide a correspondence address here.

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Part 13 – Access to Medical Reports (only applicable where your doctor is registered in the UK)

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

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 under the Access to Medical Reports Act 1988. Your rights under the act are as follows:

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.

You can ask to see the report before the doctor returns it to us; if this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not factually correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold from you access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health
 - Any care, medication or treatment you are currently receiving.
 - The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health
 - Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
 - Malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
 - Musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
 - Anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
 - Suicidal thoughts or attempts at suicide; or
 - Conditions related to drug or alcohol misuse or smoking or chewing tobacco
 - Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
 - Any blood pressure readings in the last three years
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We ask your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C;
- Any sexually-transmitted diseases unless there could be long-term effects on your health; or
- Predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from or the total sum insured is over the limit detailed in Part 10 – Health Questions.

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 question about your rights under the Act or questions relating to the process of getting, assessing or storing medical information, please write to:

The Chief Medical Officer, Friends Provident Life Assurance Ltd, PO Box 1550, Milford, Salisbury SP1 2TW

Part 14 – Declaration

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

- 1 • As Applicant, this Application is my official request to enter into a contract with Friends Provident International together providing the foregoing Cover and benefits. I understand that the contract will be on Friends Provident International's normal terms and conditions which have been explained to me.
 - I hereby declare that any information and advice about this product given by my financial adviser was given only following my/our approach to the financial adviser requesting information and advice on life assurance contracts offered by Friends Provident International.
 - I understand that Friends Provident International is subject to the supervisory arrangements and laws of the United Kingdom and not to the supervisory arrangements or laws of my habitual residence.
 - I understand Friends Provident International may require sight of the Life/Lives assured(s) medical records to consider a claim.
 - I am not residing in the United Kingdom and confirm that to the best of my knowledge and belief I am not subject to any legislation which would make this plan unlawful.
 - I understand that a copy of the terms and conditions and a copy of this completed Application are available on request.
- 2 • I have read 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 relevant fact has been withheld. I understand that failure to disclose a relevant fact or the giving of false information by any Life/Lives Assured or any Applicant(s) will give Friends Provident International the right to cancel from inception any policy issued as a result of this application and may invalidate any future claim.
 - I accept that if the Life/Lives Assured are required to have a medical examination, the replies to the medical examiner's questions will form part of this Application.
 - **I understand that I must tell Friends Provident International without delay if the health or circumstances of the Life/Lives Assured change before Friends Provident International assumes risk for the Cover applied for.**
- 3 • I understand that information given to Friends Provident International in connection with this Application may be used by Friends Provident International in its consideration of any claim in future and may be shared with a third party eg medical examiner, to help in the assessment of a claim.
- 4 • I authorise Friends Provident International to pass medical information to any life insurance company, to any medical examiner, or to any company arranging these examinations on Friends Provident International's behalf.
 - I agree Friends Provident International will use the information I give (as well as information about me relating to any existing policy I may have with Friends Provident International) for administration, underwriting, claims, research and statistical purposes. I agree Friends Provident International may pass information to medical practitioners, underwriters and reinsurers and any agency appointed for these purposes. (These agencies may be located in countries outside the UK that do not have laws to protect your information. Details of the companies and countries involved in your case will be provided on request. Friends Provident International will remain responsible for making sure that the information is held securely.)
 - I also agree Friends Provident International may pass the information to third parties for the prevention of crime or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.
- 5 • As Life Assured, 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 information when they see a copy of this consent form, including after my death to support any claim made on the plan proceeds. This information can also be used to maintain management information for business analysis.
 - † **I have read and understood Part 13 relating to Access to Medical Reports.**
 - As Life Assured, I do **not** want to see the report before it is sent to the company
 - As Life Assured, I **do** want to see the report before it is sent to the company
 - † applicable where your Doctor is registered in the United Kingdom
- 6 • I would like Friends Provident to use the information I have supplied to let me know about other products and services in the Friends Provident Group* who may use it to advise me of other products and services that may interest me.
 - * The Friends Provident Group means Friends Provident plc and any other company in which it has directly or indirectly a material shareholding.

Country where advice given

Country where Application signed

**First (or only) Life
(who will also be the Applicant if Part 12 not completed)**

**Second Life
(who will also be the Applicant if Part 12 not completed)**

Signature

Date

Signature

Date

Only complete the following if Part 12 completed

First Applicant (if applicable)

Second Applicant (if applicable)

Signature

Date

Signature

Date

If signing on behalf of a Company or partnership please state in what capacity you are signing (eg Company Secretary)

Capacity

Capacity

Part 15 – Payment Methods

GUIDANCE NOTES: Please complete in BLOCK CAPITALS the section which is appropriate for your method of payment and return the form to your Financial Adviser or Friends Provident International. DO NOT send the completed form to your Bank or Building Society.

Credit card Authority (We can only accept Mastercard, Visa and Eurocards)

(Where you are not able to make payments from an account linked to the UK clearing system)

Until further notice in writing, I authorise Friends Provident International to charge my MASTERCARD/VISA/EUROCARD* account a single unspecified sum followed by

on or immediately after / / (please insert date) and ANNUALLY/MONTHLY* thereafter. (*delete as appropriate.)

Card number	<input type="text"/>	Cardholder statement address	<input type="text"/>
Cardholder's name and initials as shown on card	<input type="text"/>		<input type="text"/>
Expiry date	<input type="text"/> / <input type="text"/>	Valid from	<input type="text"/> / <input type="text"/>
	MM / YY		MM / YY
		Signature	<input type="text"/>
		Dated	<input type="text"/> / <input type="text"/> / <input type="text"/>

Direct Debit Instruction (for GBP payments from a UK bank account only)



FRIENDS PROVIDENT INTERNATIONAL

Instruction to your Bank or Building Society to pay Direct Debits



Please fill in the whole form and send it to:

FRIENDS PROVIDENT
PO BOX 1550
MILFORD, SALISBURY
WILTSHIRE SP1 2TW, ENGLAND
Tel: +44(0) 1722 311612

1 Name and full postal address of your Bank or Building Society branch

To: The Manager	Bank or Building Society
Address	
Postcode	

2 Name(s) of account holder(s)

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

Originator's Identification Number

9	9	0	4	5	7
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3 Branch sort code (from the top right hand corner of your cheque)

<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>
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4 Bank or Building Society account number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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5 Friends Provident reference number

6 Instruction to your Bank or Building Society

Please pay Friends Provident Direct Debits from the account detailed on this Instruction subject to the safeguards assured by The Direct Debit Guarantee. I understand that this Instruction may remain with Friends Provident and if so, details will be passed electronically to my Bank/Building Society.

Signature(s)
Date

This guarantee should be detached and retained by the Payer.

The direct debit guarantee

- This Guarantee is offered by all banks and building societies that take part in the direct debit scheme. The efficiency and security of the scheme is monitored and protected by your own bank or building society.
- If the amounts to be paid or the payment dates change, Friends Provident will notify you 10 days in advance of collection or as otherwise agreed.
- If an error is made by Friends Provident or your bank or building society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a direct debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.



Part 16 – Effective date

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

Non Mortgage Related Applications

When the Cover you have applied for is assessed and accepted on our normal terms then, unless you have stated below a date on which you would like the Cover to start or have instructed otherwise, we will start the cover immediately.

If the Cover you have applied for is not accepted on our normal terms then no cover will start until we receive written confirmation of your acceptance of the revised terms.

We also need to have received your first premium payment or a completed Direct Debit or Credit Card instruction.

Effective Date

DD		MM		YY			

Mortgage Related Plans

When the Cover you have applied for is assessed and accepted on our normal terms, we shall assume risk and begin cover when you instruct us unless you have stated below a date on which you would like cover to start.

If the Cover you have applied for is not accepted on our normal terms then no cover will start until we receive written confirmation of your acceptance of the revised terms and your instructions to go on risk.

We also need to have received your first premium payment or a completed Direct Debit or Credit Card instruction.

Effective Date

DD		MM		YY			

Free Life Cover

When the Life Cover and Plan will Start

If you are taking out a new mortgage and your application has been assessed and accepted on our normal terms;

You are entitled to Free Life Cover which will start when:

- you have a definite contract for the purchase of a property (eg you have exchanged contracts) or when improvements or repair work has actually begun and
- you have received a letter from your lender offering you a mortgage

The amount of Free Life Cover is limited to the amount of your mortgage up to a maximum of GBP200,000/USD350,000/EUR300,000.

Once the Life Cover has started, please let us know when you would like the Plan to start. This must be within three months of the start of the Life Cover and is usually the completion date of your mortgage. If the Plan does not start within this three month period, your mortgage will no longer be covered if you die.

Part 17 – Details of Financial Adviser To be completed by the adviser

For completion by the Financial Adviser Company name and address (or stamp)

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E-Mail Address

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Friends Provident International Agency No.

7	9	0							
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Part 18 – Verification of Identity and Source of Funds

Please complete this form for an Individual.

Verification of Identity and Source of Funds for Individuals

Important note

For information on how to complete this form, please visit www.fpinternational.com.

The adviser must complete both sides of this form. It forms the prevention of money laundering check and is essential to the acceptance of this application. It will delay the processing of this application if not completed fully and correctly.

Verification subject: Individual

Section A

Full name	<input type="text"/>	Occupation	<input type="text"/>
Nature of Employer's business	<input type="text"/>		

Customer Type, please tick one of the boxes below:

Applicant <input type="checkbox"/>	Premium Payer/ Joint account holder <input type="checkbox"/>	Other <input type="text"/>
Please go to section B	Please go to section D	(ie Protector, Director, Shareholder, Settlor, Trustee or Major Beneficiary) Please go to section D

If the verification subject is not an applicant, please go straight to section D

Source of Funds

Section B

Please tick **one** of the following:

I can confirm the premium is:

Originating from the account details provided on the credit card mandate, direct debit mandate or cheque.
If this is being paid by third party please proceed to section C.

Being paid by telegraphic transfer and that it originates from the bank details provided below.

Account holder name(s)	<input type="text"/>	Bank name and address	<input type="text"/>
Account number	<input type="text"/>		<input type="text"/>
Sort Code/ Swift Number	<input type="text"/>		<input type="text"/>

If this is a third party please proceed to section C.

Being paid by a banker's draft. I enclose proof of purchase/remittance advice with the application.
If this is being paid by a third party please proceed to section C.

Originating from a matured/surrendered policy or a withdrawal payment from the details below.

Product provider name	<input type="text"/>	Policyholder name(s)	<input type="text"/>
Policy number	<input type="text"/>		

If this is a third party please proceed to section C.

Third Party Paying the Premium

Section C

As the premium is being paid by a third party you must complete the questions below and a separate Verification of Identity or Source of Funds form, sections A and D.

1 Please confirm the relationship between the applicant(s) and premium payer(s)

2 Please provide a detailed explanation why the premium is not being paid by the applicant

3 If the premium originates from the applicant's account via a third party account then you must provide the applicant(s) bank details below.

Account holder name(s)

Bank/credit card company

Account number

Bank address

Sort code/
Swift code

Verification of Identity and Proof of Residential Address

Section D

I am claiming the Small Premium Exemption as this premium and any premiums from existing policies the customer has, does not exceed £600pa or £50pm. I understand that if the premium exceeds the limits given above, I will be asked to fully complete a Verification of Identity and Proof of Residential address check for the individual.

OR

I have verified the identity of the individual overleaf. Details below.

The document used to verify identity must not be the same as the document used for proof of residential address.

	Verification of Identity	Proof of residential address
Type of document seen	<input type="text"/>	<input type="text"/>
Reference number	<input type="text"/>	<input type="text"/>
Issue date	<input type="text"/>	<input type="text"/>
Expiry date	<input type="text"/>	
Issuing authority	<input type="text"/>	<input type="text"/>

IFAs outside of the EU, Channel Islands, Isle of Man, Iceland and Gibraltar must provide certified copies of documentary evidence.

I/we hereby confirm that:

- A** evidence of the identity of the above has been seen in accordance with the provisions of the European Council Directive 91/308/EEC and relevant national legislation.
- B** (if premium exceeds £600pa or £50pm) I/we have identified the above and confirmed that I/we have seen the original document(s) specified, the document(s) were pre-signed and the photograph(s) bear a true likeness.
- C** I/we am/are unaware of any activities on the part of the above customer(s) which lead me to suspect that the customer is or has been involved in criminal activity or Money Laundering. Should I/we subsequently become suspicious of any such activity, I/we shall advise you immediately.
- D** I/we am/are satisfied that we could physically locate the residential address(es) by way of a recorded description or other means.
- E** the particulars given and statements made within the Source of Funds and Verification of Identity sections are to the best of my/our knowledge and belief true.

Financial adviser
Full name,
please print

Signed

Date

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Verification of Identity and Source of Funds for Non Individuals

Please complete this form for a Non-Individual

Important note

For information on how to complete this form, please visit www.fpinternational.com.

The adviser must complete both sides of this form. It forms the prevention of money laundering check and is essential to the acceptance of this application. It will delay the processing of this application if not completed fully and correctly.

Verification subject: Non Individual

Section A

Name	<input type="text"/>	Nature of Company's business	<input type="text"/>
Registration number	<input type="text"/>		
Regulatory Organisation	<input type="text"/>		

Type of Legal Entity, please tick one of the boxes below.

Private Limited Company

Public Limited Company

Charity

Local Authority

Partnership

Sole Trader

Church

Government Department

Customer type

Applicant

Premium Payer/
Joint account holder

Other

Please go to section B

Please go to section D

(ie Protector, Director, Shareholder, Settlor, Trustee or Major Beneficiary)

Please go to section D

If the verification subject is not an applicant, please go straight to Section D

Source of Funds

Section B

Please tick **one** of the following:

I can confirm the premium is:

Originating from the account details provided on the credit card mandate, direct debit mandate or cheque.
If this is being paid by third party please proceed to section C.

Being paid by telegraphic transfer and that it originates from the bank details provided below.

Account holder name(s)	<input type="text"/>	Bank name and address	<input type="text"/>
Account number	<input type="text"/>		<input type="text"/>
Sort Code/ Swift Number	<input type="text"/>		<input type="text"/>

If this is a third party please proceed to section C.

Being paid by a banker's draft. I enclose proof of purchase/remittance advice with the application.
If this is being paid by a third party please proceed to section C.

Originating from a matured/surrendered policy or a withdrawal payment from the details below.

Product provider name	<input type="text"/>	Policyholder name(s)	<input type="text"/>
Policy number	<input type="text"/>		

If this is a third party please proceed to section C.

Third Party Paying the Premium

Section C

As the premium is being paid by a third party you must complete the questions below and a separate Verification of Identity or Source of Funds form, sections A and D.

1 Please confirm the relationship between the applicant(s) and premium payer(s)

2 Please provide a detailed explanation why the premium is not being paid by the applicant

3 If the premium originates from the applicant's account via a third party account then you must provide the applicant(s) bank details below.

Account holder name(s)

Bank/credit card company

Account number

Bank address

Sort code/
Swift code

Verification of Identity and Proof of Registered Address

Section D

I am claiming the Small Premium Exemption as this premium and any premiums from existing policies the customer has, does not exceed £600pa or £50pm. I understand that if the premium exceeds the limits given above, I will be asked to fully complete a Verification of Identity and Proof of Residential address check for the company.

OR

I have verified the identity of the 'non-individual' overleaf. Details below.

Evidence of Identity

Private Limited Company

Certificate of Incorporation seen

 Yes No

 Yes No

Registered Number

Country of Origin

Date of Incorporation

Public Limited Company

Stock Exchange Check completed

 Yes No

 Yes No

Stock Exchange Daily Official List (SEDOL) number

Date of Check

Partnership

Partnership agreement seen

 Yes No

 Yes No

Reference Number

Country of Origin

Date of Agreement

Sole Trader

Evidence of Business Name seen

 Yes No

 Yes No

Type of document seen

Date of issue

Evidence of Address

Visit to Business Premises

(IFAs within UK, EU, CI, IOM, Iceland and Gibraltar only)

 Yes No

 Yes No

Date of visit

Premises entered?

 Yes No

 Yes No

Bank/Credit Card Statement seen

 Yes No

 Yes No

Reference Number

Name of Issuer

Date of Issue

Utility Bill

 Yes No

 Yes No

Reference Number

Name of Utility Company

Date of Issue

IFAs outside of the EU, Channel Islands, Isle of Man, Iceland and Gibraltar must provide certified copies of documentary evidence.

Additional Identity Information

Section D – continued

For IFAs outside of the EU, Channel Islands, Isle of Man, Iceland and Gibraltar please refer to the guidance grid for possible documentary evidence required.

1 Please provide a list of Shareholder/Directors/Partners/Signatories/Controllers/beneficial owners (as applicable). Not required for Public Limited Companies, Sole Traders, Local Authority or Government Departments

Name	Status	%

2 Please confirm you have seen one of the documents listed below, by ticking the appropriate box. Please note this only applies to Private Limited Companies.

Board of Resolution giving authority to trade or commence the relationship

Copy Register of Shareholder and Register of Directors

3 Please see guidance grid for possible further information required.

I/we hereby confirm that:

- A** evidence of the identity of the above has been seen in accordance with the provisions of the European Council Directive 91/308/EEC and relevant national legislation.
- B** (if premium exceeds £600pa or £50pm) I/we have identified the above and confirmed that I/we have seen the original document(s) specified, the document(s) were pre-signed and the photograph(s) bear a true likeness.
- C** I/we am/are unaware of any activities on the part of the above customer(s) which lead me to suspect that the customer is or has been involved in criminal activity or Money Laundering. Should I/we subsequently become suspicious of any such activity, I/we shall advise you immediately.
- D** I/we am/are satisfied that we could physically locate the residential address(es) by way of a recorded description or other means.
- E** the particulars given and statements made within the Source of Funds and Verification of Identity sections are to the best of my/our knowledge and belief true.

Financial adviser
Full name,
please print

Signed

Date

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FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Guidance Grid

Additional Identity Information

Type of Legal Entity	IFAs Inside the EU, Channel Islands, Isle of Man, Iceland and Gibraltar	IFAs Outside the EU, Channel Islands, Isle of Man, Iceland and Gibraltar
	<i>For companies inside the EU/CI/IOM, Iceland & Gibraltar</i>	<i>For companies outside the EU/CI/IOM, Iceland & Gibraltar</i>
Private Limited Company	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals</p> <p>Certified copy of list of signatories</p>	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals</p> <p>Completion of a Verification of Identity & Source of Funds form for Individuals for all of the following:</p> <ul style="list-style-type: none"> Shareholders with 5% interest or more Any ultimate beneficial owners At least two directors <p>Certified copy of list of signatories</p>
		<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals and supporting documentary evidence</p> <p>Completion of a Verification of Identity & Source of Funds form for Individuals and supporting documentary evidence for all of the following:</p> <ul style="list-style-type: none"> Shareholders with 5% interest or more Any ultimate beneficial owners At least two directors <p>Certified copy of list of signatories</p>
Public Limited Company	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals</p> <p>Certified copy of list of signatories</p>	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals</p> <p>Confirmation in writing that the company's latest reports and accounts have been seen</p> <p>Certified copy of list of signatories</p>
		<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals and supporting documentary evidence</p> <p>Certified copy of the company's latest reports and accounts</p> <p>Certified copy of list of signatories</p>
Partnership	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals</p> <p>Completion of a Verification of Identity & Source of Funds form for Individuals for all of the following:</p> <ul style="list-style-type: none"> All principal owners & controllers At least two authorised signatories <p>Certified copy of the authorised signatory list, or a list of directors</p> <p>Certified copy of list of signatories</p>	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals and supporting documentary evidence</p> <p>Completion of a Verification of Identity & Source of Funds form and supporting documentary evidence for individuals for all of the following:</p> <ul style="list-style-type: none"> All principal owners & controllers At least two authorised signatories <p>Certified copy of the authorised signatory list or a list of directors</p> <p>Certified copy of list of signatories</p>
Sole Trader	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals</p> <p>NOTE: Documents to evidence business name include; bank statement, cheque or company letterhead</p> <p>Completion of a Verification of Identity & Source of Funds form for Individuals, for the company owner</p>	<p>Fully completed Verification of Identity and Source of Funds form for Non-Individuals and supporting documentary evidence</p> <p>NOTE: Documents to evidence business name include; bank statement, cheque or company letterhead</p> <p>Completion of a Verification of Identity & Source of Funds form for Individuals, for the company owner and supporting documentary evidence</p>
Charity/Church/Club/Society/Local Authority or Government Department	Please contact Friends Provident International IFA Support for guidance	

For more information visit www.fpinternational.com

The information given in this document is based on Friends Provident International's understanding of current UK law and taxation practice, which may change. No liability can be accepted for any personal tax consequences of this scheme and for the effect of future tax or legislative changes.

Planholders who effect a Plan whilst resident in an EEA state, the Isle of Man, the Channel Islands, Iceland, Liechtenstein or Norway, have the protection afforded by the UK Financial Services Compensation Scheme (FSCS). The FSCS makes provision for payments to policyholders if a UK company is unable to meet its financial commitments.

Planholders resident in other countries when the Plan commences will not have any protection under the FSCS.

Complaints we cannot settle can be referred to the Financial Services Ombudsman.

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

Friends Provident International is the trading name of Friends Provident Life Assurance Limited for business conducted outside the United Kingdom

Registered and Head Office: Pixham End, Dorking, Surrey RH4 1QA England
Incorporated company limited by shares and registered in England number 782698

Member of the Friends Provident Marketing Group and authorised and regulated in the United Kingdom by the Financial Services Authority
Member of The Association of International Life Offices

Salisbury Office: United Kingdom House, Castle Street, Salisbury, Wiltshire SP1 3SH England
Telephone +44(0) 1722 311611 Fax +44(0) 1722 332005
E-mail fp.int@friendsprovident.co.uk Website www.fpinternational.com

The rules and regulations made by the Financial Services Authority for the protection of investors will not normally apply to persons resident outside the United Kingdom



FRIENDS PROVIDENT
INTERNATIONAL