



Confidential Client Questionnaire

APPLICANT 1 NAME: _____

APPLICANT 2 NAME: _____

DATE: _____

ADVISER: _____ SOURCE OF INTRODUCTION: _____

MEETING VENUE: FACE TO FACE/TELEPHONE/ZOOM/MICROSOFT TEAMS/OTHER

We prepare this document to help us tailor and fulfil your financial goals.

Our relationship is built on trust and your belief that we want to help you shape and protect your future.

Our business thrives on referrals, so we appreciate it when our existing clients refer us to friends or family.

Please tell us if there is someone you know, who could benefit from our services

YOUR HOME MAY BE REPOSSESSED IF YOU DO NOT KEEP UP REPAYMENTS ON YOUR MORTGAGE

14 U Financial Solutions Ltd is an appointed representative of PRIMIS, a trading style of First Complete Ltd which is authorised and regulated by the Financial Conduct Authority

96 Dufferin Avenue, Bangor, Co Down, BT20 3AD

Tel: 028 91 456262 .

Email: info@14Ufinancialsolutions.co.uk . www.14Ufinancialsolutions.co.uk

Company No.: NI 606059 Registered in Northern Ireland

Service Agreement

We believe that relationships are everything, so we are committed to offering our clients the highest possible standards of service.

We provide a full advice and recommendation service. To ensure the advice we give is appropriate for you, it is important that we fully understand your circumstances, as well as your needs and plans for the future. Please help us, to help you, by giving full and accurate information in all areas of our discussions with you. Please be patient us, as we gather your details on this occasion. We hope that you will become a long-standing client and so this process will be easier in the future, when you will only need to update us with changes to your circumstances and plans.

What happens now?

- *Completion of detailed questionnaire to establish your circumstances and requirements*
- *Based on these discussions we will research the market in all areas. At a second meeting, normally within one week, we will present you with reports on our personalised recommendations. We will only recommend suitable products that you can afford.*
- *At our meetings we will complete all appropriate paperwork to progress applications*
- *We will deal with all aspects of the application processes on your behalf. We will deal with the product providers by telephone and mail until your funds have been released or your policy placed on risk.*
- *Where relevant we will place all your Life Policies in Trust, carrying out meetings with all Trustees to explain their duties and responsibilities.*
- *On final completion, we will meet again, to ensure you fully understand what we have put in place; answer any questions and provide you with a pack of all-important documents, for safe keeping*

Our Fees

We charge a broker fee of £199 on application and £190 on completion of your mortgage.
We do not charge fees for insurance advice.

Our on-going relationship with you

When you become our client, we consider it our on-going responsibility to ensure your financial products continue to be appropriate to your circumstances and requirements. Regular reviews are paramount, and we recommend these at regular intervals. Please confirm your preference

6 months 9 months 12 months

I would prefer to be contacted by:

<i>Mobile Phone Y/N</i>	<i>Home Phone Y/N</i>	<i>Work Phone Y/N</i>	<i>Email Y/N</i>	<i>No Preference Y/N</i>
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I / we agree to further contact as described above **YES / NO**

IT IS YOUR DUTY TO FULLY AND ACCURATELY DISCLOSE ALL MATERIAL FACTS

General Data Protection Regulation

Our company is an Appointed Representative of PRIMIS Mortgage Network, a trading name of First Complete Limited, which is authorised and regulated by the Financial Conduct Authority (FRN:435779). PRIMIS Mortgage Network will process all information in accordance with General Data Protection Regulations and it will be treated as private and confidential now and in the future. The only exceptions to this will be when the law requires us to disclose information or, with your consent, where disclosure is necessary when arranging or servicing your mortgage or protection contracts. To fulfil our regulatory obligations, we will retain copies of your records for no longer than is necessary or for the duration of the contract. You have the right to inspect these records at any time.

A copy of our Privacy Statement is available with further details on how we will use your personal information.

<i>I / we have read, understood and agree to the above Data Protection Declaration</i>	YES / NO
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By signing this document I / we are confirming that I/we agree to the above methods and levels of contact and to the Data Protection Statement. I/We am/are also confirming that the information provided is a full and accurate account of our circumstances and requirements.

Inaccurate information provided for a mortgage application could lead to your application being classified as fraudulent. Information not being disclosed for a protection application could result in non-payment of a claim.

Date:	Signature: Applicant 1	Signature: Applicant 2
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Your Objectives

Primary Objective <i>First Time Buyer</i> <i>House Purchase/Home Mover</i> <i>Further Advance/Additional Borrowing</i> <i>Re-mortgage</i> <i>Right to Buy</i> <i>Shared Ownership / Co-Ownership</i> <i>Holiday Home</i> <i>Consumer Buy To Let</i> <i>Investment Buy To Let</i> <i>Holiday Let</i> <i>Retirement Interest Only</i>	<i>Protection Review – Life, Critical Illness, Income Protection</i> <i>Buildings and Contents Insurance</i> <i>Landlord Insurance</i> <i>Private Medical Insurance</i> <i>Trusts</i>
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IT IS YOUR DUTY TO FULLY AND ACCURATELY DISCLOSE ALL MATERIAL FACTS

Personal Details

	Applicant 1	Applicant 2
Title		
Forename		
Surname		
Date of Birth		
Smoked in last 12 months		
Marital Status		
Date Married		
Previous / Maiden Name		
Name(s) and dates of birth of child/children		
Current address		
<i>Owned / Rented / Parental Home</i>		
Time at address	From __/__/__	From __/__/__
Previous address		
Time at address	From __/__/__ To __/__/__	From __/__/__ To __/__/__
<i>Owned / Rented / Parental Home</i>		
Are you on the Electoral Register	YES / NO	YES / NO
Home Telephone Number		
Mobile Number		
Work Telephone Number		
Email		
UK National	YES / NO	YES / NO
Nationality		

Estate Planning

Do you have a will		
Do you have a pension		
Security – Mother’s Maiden Name		

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Employment

	Applicant 1	Applicant 2
Employment (<i>Employed / Self-Employed / Company Director - % share if company director</i>)		
Basis of Employment	<i>Full time / Part Time / Contract / Permanent / Temporary</i>	<i>Full time / Part Time / Contract / Permanent / Temporary</i>
Anticipated Retirement Age		
National Insurance Number		
Occupation		
Start date of current occupation		
Probationary Period If yes please give end date	Y/N	Y/N
Name & Address of Employer / Place of Business if Self Employed		
Telephone Number		
Business Type		
Employer benefit if you are Sick	SSP Wks Full Pay Wks Half Pay	SSP Wks Full Pay Wks Half Pay
Previous Employment details (less than 1 year) Occupation Names/Address of Employer Telephone Number Dates Employed: From – To Annual Salary		
Accountant Name and Address - if self-employed		
Qualifications		
If Self Employed, No. of years accounts available		

Income

Employed / Company Director

Annual Basic Salary (Gross)	£	£
Annual Guaranteed Overtime or Bonus (Gross)	£	£
Annual Non-Guaranteed Overtime or Bonus (Gross)	£	£
Annual Profit Share/ Dividend/ Other (Gross)	£	£
Annual Total earned income (Gross)	£	£
Monthly earned income (Net – after deductions)	£	£
Monthly Tax Credit/Universal Credit	£	£
Monthly PIP/DLA		
Monthly Child Benefit (Convert 4 weekly payment to mthly)	£	£
Monthly Maintenance Income		
Monthly Total Net Income	£	£

Self Employed

Net Profit year end / /	£	£
Net Profit year end / /	£	£
Net profit year end / /	£	£

Notes:

Annual Tax Credits/Universal Credit £ Annual Child Benefit £ Annual PIP/DLA Other £	Provide Further information on Bonus Frequency/How Maintenance Payments Made etc
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Credit History (use additional information page if necessary)

	App 1	App 2
Have you ever failed to keep up regular payments on your Mortgage/Loans/HP Agreements/Credit Cards/Store Cards/Mobile Phone	YES / NO	YES / NO
If so please provide details i.e. Month, Year, Amount		
Have you ever had a county court judgement registered against you?	YES / NO	YES / NO
If so please provide details i.e. Month, Year, Amount		
Have you ever been bankrupt?	YES / NO	YES / NO
If so please provide details i.e. Month, Year		
Have you ever had a mortgage or loan application declined?	YES / NO	YES / NO

Debt Details – including Student Loans and credit cards that are paid monthly

	Lender & Type	App 1 App 2	Latest Balance	Credit Limit	APR	End Date	Min Mth %	Monthly Payment	Repaid by Completion	ERC
1			£	£				£	YES / NO	
2			£	£				£	YES / NO	
3			£	£				£	YES / NO	
4			£	£				£	YES / NO	
5			£	£				£	YES / NO	
6			£	£				£	YES / NO	
7			£	£				£	YES/NO	
8			£	£				£	YES/NO	

Existing Mortgages

Property Ref				
Is the property Residential or BTL				
Residential Type				
Name of Current Lender				
Mortgage Account Number				
Outstanding Mortgage Amount	£			£
Current Value	£			
Original Purchase price	£	£	£	£
Date Purchased	__/__/__	__/__/__	__/__/__	__/__/__
Mortgage Type	(Repayment / Interest Only/Split)	(Repayment / Interest Only/Split)	(Repayment / Interest Only/Split)	(Repayment / Interest Only/Split)
Variable/Fixed/Capped/Discounted/Tracker				
Original Mortgage Term				
Remaining term	yrs mths	yrs mths	yrs mths	yrs mths
Current monthly repayment	£			
Current Interest Rate	%	%	%	%
Expiry Date	__/__/__	__/__/__	__/__/__	__/__/__
Do you have any Arrears	Y/ N	Y/ N	Y/ N	Y/ N
If Yes, Please Give Details:	£	£	£	£
Are these arrears to be consolidated	Y/ N	Y/ N	Y/ N	Y/ N
Early repayment charge	Y/ N	Y/ N	Y/ N	Y/ N
Amount of charge	£			
End Date for early repayment charge	--/--/--	Y/ N	Y/ N	Y/ N
Is the Property being sold	Y/ N	Y/ N	Y/ N	Y/ N
Are your current Mortgage Terms Portable	Y/ N	Y/ N	Y/ N	Y/ N

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Other Properties

Property Address		Type of Property: House / Apartment / Bungalow / Detached / Semi Detached / Terrace / End Terrace		
		If apartment on which Floor		<input type="text"/>
		How many floors in block		<input type="text"/>
Date Purchased	Yr Built	Freehold / Leasehold	Yrs Left on Lease	
Rental Income		Management Fees pa £	Ground Rent pa £	
Letting Agent Yes / No		Family Member / Private tenant / DSS / Student / Holiday Let/HMO		
Reception Rooms	Bedrooms	Bathrooms/WC /	Kitchens	Garage/Parking
EPC Rating		Solar Panels Y/N	Owned/Leased	
Cladding Report Available if Apartment Y/N		Roof Foam Insulation Y/N	Certificate of Fitness Y/N pre 1956	

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Cladding Report Available if Apartment Y/N		Roof Foam Insulation Y/N	Certificate of Fitness Y/N pre 1956	

Other Details

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Expenditure - £ per calendar month

Utility Bills	Total New Mortgage	Applicant 1	Applicant 2
Mortgage / Rent			
Electricity			
Gas/Oil			
Water			
Rates / Council Tax			
Building and Contents Insurance			
TV Licence			
TV Package			
Phone/Internet			
House Maintenance/Ground Rent/Management Fees			
TOTAL UTILITY BILLS			
Regular Monthly Outgoings			
Childcare/ School Fees			
Maintenance / Child Support			
Life / Critical Illness Policies			
Income Protection Policies			
Dental/Private Medical Insurance			
Pet Insurance			
Pensions			
Food			
Clothes			
Vehicle Costs Tax / Insurance / Maintenance			
Fuel and Other Travel/Bus/Train/Taxi			
Bank Fees			
TOTAL REGULAR EXPENSES			
Non-essential Outgoings			
Holidays			
Cigarettes / Alcohol /Eating Out/Socialising			
Hobbies			
Subscriptions			
Mobile Phones			
Regular Savings			
Medicines/ Hairdressing/Other Personal Items			
Gifts/Christmas/Birthdays			
Charity			
All other Expenditure			
TOTAL NON ESSENTIAL OUTGOINGS			
TOTAL OUTGOINGS			
Credit Cards			
Loans			
Utility Bills			
Regular Monthly Expenses			
Non-essential Outgoings			
TOTAL			

Are you expecting any changes to your income or Expenditure?

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Landlord Details if Renting

Estate Agent Details	Solicitor Details We can get you a quote for Conveyancing
Firm Name Address Tel No: Contact Name	Contact Name Firm Name Address Tel No: E-mail:

What are the access details for the Surveyor

Please provide your main current account details:

	Applicant 1		Applicant 2
Bank Name		Bank Name	
Branch Address		Branch Address	
Branch Post code		Branch Post code	
Sort Code		Sort Code	
Account Number		Account Number	
Length of time account held		Length of time account held	
Use for new mortgage Direct Debit?	YES / NO	Use for new mortgage Direct Debit?	YES / NO

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PROTECTION

What Life/Critical Illness/Income Protection/ Cover do you currently have?

App 1/2/Jnt	Provider Name	Policy Number	Type of Cover	Level of Cover	Level/Indexed Decreasing	Commenced/ End Dates	Monthly Premium

Buildings and Contents Cover

Current Insurer:	
Policy Number:	
Monthly Premium:	
Renewal Date:	
Are you a first-time buyer?	
Have you or any member of your family ever been refused insurance?	
Have you or anyone in your household have insurance cancelled, declined void or had any special terms imposed?	
Do you or anyone in your household have any unspent convictions or prosecutions pending?	
Have you or anyone in your household suffered a loss or damage whether insured or not in the last 5 years – if yes please give details	
How many years, no claims discount do you have?	

Property Details

Is the property in a Neighbourhood watch area?	YES / NO
Is the property listed =Yes Preservation Order/Yes Grade 1-Grade 2-Grade 2*/NO	
Walls – Brick / Concrete / Stone	
Roof – Tiles / Slates / Felt on Timber	
What percentage of the roof is flat?	0-100%
Is your property used for business purposes other than clerical work undertaken by you or your family	YES / NO
Is the property let through a management company?	YES / NO
If yes give name and address of company:	
Windows – Key operated locks / No Specific Security	
Doors – Mortice Deadlock – 5 or more levers / Mortice Deadlock – 5 or more levers BS3621 / Rim Deadlock / Key operated Multi point locking system / Not Listed or No specific security	
Alarm – No alarm / Non-maintained alarm / Annually maintained alarm	
Does the property have smoke alarms?	YES / NO
Is the property generally left unoccupied during normal working hours?	YES / NO
Is the property generally left unoccupied at night?	YES / NO
Has the home or land belonging to it flooded in the last 15 years?	YES / NO
Does the property have any signs of, or has ever had any damage caused to it by landslip, subsidence or heave?	YES / NO
Is the property undergoing renovation or in a poor state of repair?	YES / NO
Is the property occupied solely by you / your tenant?	

Required Features

Buildings Insurance Amount of Cover	£
Contents Insurance Amount of Cover	£
Accidental Damage	YES/NO
How much unspecified personal possessions cover do you require?	£
Excess	£
Legal cover	YES/NO
Home Emergency	YES/NO
Rent Guarantee	YES/NO – if yes amount £
Trace and Excess	YES/NO
Unoccupied property cover	YES/NO
Malicious Damage by Tenant	YES/NO
Details of individual items over £1,500. Eg: jewellery / works of Art	

Protection Requirements

Have you considered the impact if

1. You died tomorrow?
2. You were diagnosed with a Critical Illness?
3. You were off work long term sick?
4. You lost your job?

Which of the following are important to you, for your wife/husband / children in the event of serious illness or death?

Please Tick as appropriate or add your own priorities

LIFESTYLE	ESSENTIAL	DESIREABLE	NO
To remain in the family home (afford running costs)			
Wife/Husband can stay at home to look after children			
Daily Living Expenses Covered at current standards			
Car			
Holidays			
University Education / childcare			
Hobbies and Entertainment			
Current Toys/Gadgets/Fashion			
Deposits for children's first home.			
Wedding costs for children			
Children's cars			

What is the monthly income required to provide this?

If you died now, how would your family's lifestyle be affected?

What if you live but you suffer a critical illness?

What if it is long term sickness or unemployment?

SSP - paid by employers up to 28 weeks of sickness - £88.45 pw

ESA - £57.90 / £73.10 (under 25 / over 25) paid for first 13 weeks, rising to £102.15 in work related group or £109.30 in support group

How would your family react to living like this?

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GP Details

	Applicant 1	Applicant 2
Name of Surgery/GP		
Address of Surgery		
Telephone Number		
Do you wish to see the GP report before being sent to the insurer? (This will delay your application).	Yes/No	Yes/No

Personal Details

	Applicant 1	Applicant 2
Have you ever been turned down or been offered special terms by any Company?	Yes / No	Yes / No
Have you ever made an Income Protection claim or Critical Illness claim?	Yes / No	Yes / No
Height		
Weight		
Waist size (men) / skirt size (women)		
Have you recently lost/gained weight you can't explain? If so how much and over what period and reason?		
How many of the following do you drink on average per week		
Pints of Beer, Cider or Lager:		
Small glasses of wine (175 ml):		
Large glasses of wine (250ml):		
Single measures of spirits, shots or bottles of alcopops:		
How many units between Mon-Thurs / Fri-Sun	/	/
Have you ever reduced the amount of alcohol you drink for any of the following reasons?		
<ul style="list-style-type: none"> • You were advised by a medical professional? • Alcohol was causing or contributing to health problems? • Alcohol impacted your work or your ability to carry out your day to day activities? 		
Which of the following describes you:		
Have you ever smoked? including e-cigarettes.	Yes / No	Yes / No
Date started / stopped	/	/
How many cigarettes do you smoke per day?		
Smoke occasionally or socially only?	Yes / No	Yes / No
Have you ever used Nicotine replacement products?	Yes / No	Yes / No
Give dates started / stopped		
Have you ever used any of the following: Recreational drugs, for example cocaine, cannabis, ecstasy, heroin, methadone etc., Stimulants, sedatives, tranquillisers or anabolic steroids that have not been prescribed by a doctor	Yes / No	Yes / No
If yes please give details		

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Medical History

Have you ever had or do you currently have any of the following:

Cancer, Leukaemia, Hodgkin’s disease, Lymphoma, brain or spinal tumour	Yes / No	Yes / No
Heart disease (including heart attack, angina, heart defects from birth or heart surgery)	Yes / No	Yes / No
Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson’s disease, Paralysis, epilepsy, Alzheimer’s disease, dementia or cerebral palsy	Yes / No	Yes / No
Any other disorder of the arteries (including disease in the legs or of the aorta)	Yes / No	Yes / No
Diabetes or sugar in the urine	Yes / No	Yes / No
Mental illness that has required treatment or referral to a psychiatrist	Yes / No	Yes / No
Any nervous or mental disorder – eg anxiety, stress, depression, schizophrenia, suicide attempt or nervous breakdown	Yes / No	Yes / No
Stroke, mini stroke, transient ischaemic attack (TIA), brain haemorrhage, brain aneurysm or brain damage?	Yes / No	Yes / No
Any condition of the central nervous system (the brain, spinal cord and nerves), multiple sclerosis, optic/retrobulbar neuritis, cerebral palsy, paralysis, Parkinson's disease, Alzheimer's disease or dementia?	Yes / No	Yes / No
Blurred or double vision, numbness, loss of feeling or muscle power, balance problems, or persistent pins and needles or facial pain serious enough to seek medical advice?	Yes / No	Yes / No
Epilepsy	Yes/No	Yes/No

If you answered yes to any questions in this section, please complete the Further Information section

Recent Health

In the last 5 years have you had any of the following:

Asthma or any condition affecting your lungs or breathing (other than hay fever)?	Yes / No	Yes / No
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol	Yes / No	Yes / No
A lump, growth, polyp or tumour of any kind, or a mole or freckle that has bled, itched, become painful, changed colour or increased in size, regardless of whether or not you have consulted a doctor?	Yes / No	Yes / No
Numbness, loss of feeling or tingling of the limbs or face, loss of balance or co-ordination	Yes / No	Yes / No
Seizures, fits, fainting or blackouts	Yes / No	Yes / No
Any problems with your eyes or ears which haven't been fully corrected by glasses/hearing aids?	Yes / No	Yes / No
Any pain or restriction in movement in the back, neck, shoulder or joints (including traumatic injury), a slipped disc, sciatica, rheumatic, arthritic or muscular complaints including gout, repetitive strain injury, neuralgia or fibromyalgia?	Yes / No	Yes / No
Any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, hepatitis, colitis or Crohn’s disease)	Yes / No	Yes / No
Any blood disorder	Yes / No	Yes / No
Any thyroid disorder	Yes / No	Yes / No

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Any disorder of the kidney, bladder or genitor urinary system (including urinary tract infections and blood or protein in the urine)	Yes / No	Yes / No
Females only – an abnormal cervical smear/mammogram	Yes / No	Yes / No
Males only – Prostrate enlargement or raised PSA		
Treatment or a positive test for any disease which was transmitted sexually	Yes / No	Yes / No
Any skin disorder – eg eczema, psoriasis or any other skin disorder in the last 5 years	Yes / No	Yes / No
Have you had any recurrent insomnia or sleeping difficulty or recurrent tiredness or fatigue in the last 5 years	Yes / No	Yes / No
Have you had memory loss, confusion or changes to your concentration levels or communication skills?	Yes/No	Yes/No

Health Consultations

Other than consultations to do with the points on the already mentioned, have you had a medical consultation in the last 24 months (eg doctor, consultant, psychiatrist, hospital, clinic, osteopath) How many times?	Yes / No	Yes / No
Have you ever had (or been advised to have) any medical investigation, scan, test or attended hospital in the last 5 years?	Yes / No	Yes / No
Are you under routine medical review or awaiting a consultation with a specialist for any medical condition?	Yes / No	Yes / No
Have you taken any medication which requires a prescription from your doctor or other health professional in the last month?	Yes / No	Yes / No
Have you ever tested positive for HIV, Hepatitis B or C or are you waiting the results of such a test	Yes / No	Yes / No
Within the last 5 years have you been exposed to the risk of HIV infection? (through unsafe sex, intravenous drugs abuse, blood transfusion or surgery taken outside the EU).	Yes / No	Yes / No
Have you ever undergone any surgical procedure outside the EU or been a recipient of blood products outside the EU	Yes / No	Yes / No
Experiencing symptoms or a condition that you're likely to seek medical advice or treatment for in the near future?	Yes / No	Yes / No
Or do you currently have any physical or mental condition that restricts or causes difficulties in performing your daily activities or your occupation?	Yes / No	Yes / No
Been absent from work or unable to perform your daily activities due to illness, disorder or injury for more than two weeks at a time in last 5 years?	Yes / No	Yes / No
Currently absent from work	Yes / No	Yes / No

Recent Health – If you answered Yes to any questions – please provide further details

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Recent Health – If you answered Yes to any questions – please provide further details

Asthma Questionnaire

Please complete if you suffer from/are being treated for Asthma

When did you last experience symptoms of this condition?		
Have you been admitted to hospital within the last 2 years with this condition?		
How many days have you taken oral steroid tablets in the last 2 years?		
How many days have you taken off work or been unable to follow your normal daily activities, because of this condition in the last 2 years?		

Diabetes Questionnaire

Please complete if you suffer from / are being treated for diabetes

Type of diabetes – type 1 or 2		
Date of your last review		
Most recent HBA1C reading		
Have you been on insulin since diagnosis?		
Have you been advised of protein in urine?		
Do you experience tingling or numbness in fingers or toes?		
Have you had any hospital admissions due to your diabetes? If yes please give dates and frequency		
Are you on treatment for raised blood pressure or raised cholesterol due to diabetes?		

Blood Pressure Questionnaire

Please complete if you are being treated/under review for your blood pressure

Date blood pressure was first noted to be raised/lowered		
Date of last blood pressure reading		
Actual reading		
Are you taking medication for this		
Type of medication		
How often is your blood pressure monitored		
Has your treatment been changed in the last 6 months or has the doctor reduced the time between reviews		
Have you ever had any heart or circulatory problems or raised cholesterol?		
Have you ever had any kidney problems such as protein in your urine?		
Do you experience any symptoms or side effects, such as dizziness or headaches?		
Have you ever not taken or stopped treatment without your doctor's approval?		
Are you awaiting hospital referral or investigations for your condition?		

Recent Health – If you answered Yes to any questions – please provide further details

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Cholesterol Questionnaire

Please complete if you are being treated/under review for your cholesterol

Date cholesterol was first noted to be raised		
Date of last cholesterol reading		
Actual reading		
Are you on medication?		
Details of medication		
How often is your cholesterol monitored?		
Has your treatment been changed in the last 12 months or has the doctor reduced the time between reviews?		

Depression/Anxiety/Stress Questionnaire

Please complete if you are being treated/under review for Depression/Anxiety/Stress

Which condition do you suffer from?	
Have you seen any other health professional apart from your GP in relation to your depression/anxiety/stress?	
Have you had any change to your treatment in the last year?	
Please provide details of current medication?	
When did you last experience symptoms of depression/anxiety?	
Have you ever experienced suicidal thoughts/feelings; self-harmed or attempted suicide?	
Was your depression/anxiety linked to a specific event?	
Have you taken any time off work in relation to this condition?	
If yes please give dates	

IT IS YOUR DUTY TO FULLY AND ACCURATELY DISCLOSE ALL MATERIAL FACTS

Family History

Have either of your natural parents, brothers or sisters suffered or died before the age of 65 from any of the following:

	Applicant 1	Applicant 2
Heart attack, angina or stroke	Yes / No	Yes / No
Type 2 Diabetes	Yes / No	Yes / No
Cardiomyopathy	Yes / No	Yes / No
Breast, ovarian, colon or bowel cancer	Yes / No	Yes / No
Cancer of another site (cancer other than of the ovary, breast, colon or bowel) including lymphoma	Yes / No	Yes / No
Familial adenomatous polyposis (FAP) / polyposis coli	Yes / No	Yes / No
Multiple sclerosis	Yes / No	Yes / No
Motor neurone disease	Yes / No	Yes / No
Muscular dystrophy	Yes / No	Yes / No
Huntington's disease	Yes / No	Yes / No
Parkinson's disease	Yes / No	Yes / No
Alzheimer's disease	Yes / No	Yes / No
Polycystic kidney disease	Yes / No	Yes / No
Any other inherited condition that runs in your family and that you have had or been advised to have screening for	Yes / No	Yes / No
None of these, don't know as I have no further contact with family members or don't know as I am adopted	Yes / No	Yes / No

If Yes to Family History please provide further information

Disease		
Family Member		
Age Diagnosed		

Disease		
Family Member		
Age Diagnosed		

Is your mother still alive	Yes / No	Yes / No
Please state the age she is now or the age she died: If dead, please give exact age at death	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n
Is your father still alive	Yes / No	Yes / No
Please state the age he is now or the age he died: If dead, please give exact age at death	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n
If you are unsure of any of the answers, please tell us why:	Yes / No	Yes / No

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Occupation Details

What % of your time would you spend doing manual work (standing, walking, lifting, carrying, moving goods, working with tools or machinery)		
Please provide details of machines/tools used.		
What manual work do you carry out		
What % of your time do you spend driving		
Business miles travelled per year (not commuting to and from work)		
Hours worked per week		
Are you likely to travel as part of your occupation to countries where there are areas of internal conflict or insecurity (other than as a member of the Armed Forces)?	Yes / No	Yes / No
Do you work outside of the UK for more than 90 days a year?	Yes / No	Yes / No
Do you have a second job?	Yes / No	Yes / No
If yes, what is your occupation?		

Does your occupation involve any of the following:-

Working at heights over 15 metres / 50 feet	Yes / No	Yes / No
If so, what is the highest & average height you work at and how often?		
Working under ground	Yes / No	Yes / No
Working under water	Yes / No	Yes / No
Working offshore (eg oil, gas industry)	Yes / No	Yes / No
Working with explosives or firearms	Yes / No	Yes / No
Armed forces	Yes / No	Yes / No
Professional Sports	Yes / No	Yes / No
Aviation (except as a fare paying passenger)	Yes / No	Yes / No

If you answered yes to any of the questions in Occupation Details, please give further details below:

Applicant 1	Applicant 2

Lifestyle

How many times a week do you exercise for at least 30 mins:		
Have you ridden a motor cycle on the road in the last 12 months?		
If Yes: what is the cc capacity of your bike?		
How long have you held a motorbike licence?		
What mileage do you do per year?		

IT IS YOUR DUTY TO FULLY AND ACCURATELY DISCLOSE ALL MATERIAL FACTS

Lifestyle Continued:

Have you ever been banned from driving, in a road traffic accident that was your fault or do you have any motoring prosecutions pending?	Yes / No	Yes / No
If yes – how many driving bans have you had		
How many accidents have you had which were your fault:		
Have you had any further points on your licence since your ban?	Yes / No	Yes / No

Residency / overseas travel / sport

During the last three years, have you spent more than 90 days in total in Africa, the Caribbean, Russia, Thailand or Ukraine?	Yes / No	Yes / No
Are you currently living outside of, or during the next 12 months do you intend to spend more than 30 days outside of:		
{The EU or other Western European countries}, {North America}, {Australia or New Zealand}	Yes / No	Yes / No
Do you take part in any of the following activities?		
Underwater diving	Yes / No	Yes / No
Mountaineering or rock climbing	Yes / No	Yes / No
Caving or potholing	Yes / No	Yes / No
Any extreme sport, for example bungee jumping (other than one-off bungee jumps), white water rafting, cliff or free diving, etc.	Yes / No	Yes / No
Flying (other than as a fare paying passenger), hang gliding or paragliding, parachuting, skydiving or base jumping	Yes / No	Yes / No
Motorcar or motorbike racing	Yes / No	Yes / No
Powerboat racing	Yes / No	Yes / No
Trans-ocean sailing or offshore racing	Yes / No	Yes / No
Full contact martial arts, combat sport or boxing	Yes / No	Yes / No
Equestrian sport or private hacking / Horse Riding	Yes / No	Yes / No
Winter sports other than holiday skiing or snowboarding for pleasure	Yes / No	Yes / No

Additional Information

<p>If you take part in Motor Sports please ensure you have included the following information:- TYPE of racing, MAKE, MODEL and CC of vehicle How many races and which circuits you race at How long you have been racing Give details of any injuries</p>

Direct Debit Details

Account Holder	
Name of Bank	
Branch	
Sort Code	
Account Number	
Preferred Date of Collection (1 st – 28 th)	

Agreed follow up/Action

Mortgage:

Protection/Income Protection:

Buildings and Contents Insurance:

Wills/Pensions/Investments/Commercial Insurance:

SUPPLEMENTARY QUESTIONS COVID-19

**Regardless of anything you've told us about
Have any of the following applied to you in the last 3 months**

Tested positive for Coronavirus?	Y/N
Been personally advised to self-isolate by a medical professional or NHS 111 but have not been diagnosed with Coronavirus and are still self-isolating?	Y/N
Had direct contact with someone who's been confirmed or suspected to have Coronavirus? You can answer no if the only contact is related to working within the medical profession.	Y/N
Do you have continuing symptoms, suspected to be Coronavirus such as a continuous cough, high temperature, loss of taste or smell, fatigue or body aches?	Y/N

If you have answered yes to any of the above, please provide further details, including dates, symptoms, duration, and treatment.