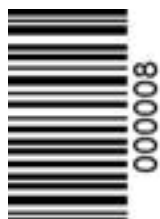




COMPANY PENSION LIFE INSURANCE APPLICATION DETAILS



Before you give us your personal information please note that Irish Life has a Data Privacy Notice. This explains what your data protection rights are and how and why we use your personal information. This is always available on our website at www.irishlife.ie or you can ask us for a copy by using the contact details below.

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.

If any item is blank or illegible, this will cause a delay in processing your application.

Financial Adviser Details

Financial Adviser Name

Financial Adviser Code

If your Financial Broker or Adviser submits your application electronically Irish Life will only receive a copy of the Declarations section of this form. The original application form will be retained by your Financial Broker of Adviser and not checked by Irish Life.

1. Personal Details

Title (Mr/Mrs/Ms etc)

First Name

Surname

Date of Birth (dd/mm/yyyy)

Age Next Birthday

Gender

Male

Female

Relationship Status

Single

Married

Widowed

Separated

Divorced

Registered Civil Partner

Country of Birth

Country of Nationality

During the last 12 months, which of the following best describes your smoking habits:

Smoker

Occasional smoker

Used nicotine replacement products or E-cigarettes

Non Smoker

Previous Surname (if any)

Occupation

Chosen Retirement Age

Level of Earnings

€

each year

PPS Number

Address

Mobile Number

Home/Work Number

Email

We are obliged to establish Country of Nationality to comply with Anti Money Laundering requirements.

A Non-smoker has not smoked or used any nicotine replacement products or E-cigarettes in the last 12 months

Chosen retirement age must be between 60 and 70

We need this information to ensure that the level of cover suits your circumstances

We require your PPSN to obtain approval from the Revenue Commissioners

2. Employer Details

Name of employer

Company registered number

Address for correspondence

Employer contact name

Employer contact phone number

3. Revenue Information

Address of the registered office
of the employer

Does the employee have other pension benefits from previous/current employments? Yes No

If YES, please complete the Previous Pension details in CAB

Please give plan numbers of any existing Irish Life Pension contracts in respect of this employee

Employee's tax district

Employer's tax district

Employer's PRSI Number

4. Politically Exposed Person (PEP) or Relative or Close Associate (RCA) of a PEP

Are you or any of the Beneficiaries, Trustees, Settlers, Appointers or in the case of a Company Owner, Director, Beneficial Owner (or have been within the last 12 months), a PEP or RCA ? Yes No

5. Company Pension Term Assurance

Amount of Life Cover you want €

Age at which cover should cease

Do you want inflation protection? Yes No

Do you want Guaranteed Cover again (convertible option)? Yes No

Is the cover to start immediately? Yes No

If Yes, please complete the Politically Exposed Person (PEP) or Relative or Close Associate (RCA) Supplementary Form. An explanation of these terms is provided in Supplementary Form

At any time up to the end of the term, you have the option to convert to another life cover plan. The exact definition and terms available in the policy document. The option of Guaranteed Life Cover again only applies to a maximum Life Cover of €1 million. These limits are in respect of the total cover converted across all policies belonging to the life assured.

If not please let us know later when you want cover to start

6. Payment Details

Premium amount

€

Frequency of Direct Debit

Every Month

Every 3 Months

Every 6 Months

Every Year

1st to 28th of month

What date of the month do you want your Direct Debit taken?

Cheques for regular contributions can only be made when contributions are made on a yearly basis and exceed €600

If NO we will contact your financial adviser for confirmation of the start date

Do you want your cover to begin immediately, if accepted?

Yes

No

7. Communications and Transactions

How would you like to receive your plan communications from us? (for example, your welcome pack, letters and regular statements). Please tick one option:

Online

By Paper Post

Plan Schedule by post everything else electronically

Yes

No

Would you like the original plan schedule to be sent to the adviser?

Yes

No

Is the plan being set up under a conversion of an existing Irish Life Plan?

Yes

No

If you do not choose an option we will assume you want to receive communications by paper post. Your Plan communication will be securely stored in your personal online account at www.irishlife.ie. You will be notified by text and email when communications are added to your account.





UNDERWRITING QUESTIONS

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.

If any item is blank or illegible, this will cause a delay in processing your application.

Medical and Other Information

Your personal health information:

In addition to our Irish Life Data Privacy Notice, the following is more detail relating to your personal health information that we collect and use in connection with this plan contract.

We need your relevant personal information and personal health information for underwriting decisions. This will determine whether we can offer cover and on what terms. We also need your relevant personal information and personal health information to assess and pay claims. If relevant, we will share your personal health information with reinsurers and Chief Medical Officers for underwriting and claims decisions. We can use your personal information and personal health information for any subsequent applications to Irish Life.

In addition to the personal health information we collect from you, we may request and receive your relevant personal health information from GPs, consultants, hospitals or other health professionals, and share your relevant personal health information with GPs, consultants, hospitals or other health professionals, if needed.

Duty of Disclosure:

When deciding whether to insure you and when setting the terms and premium, we will rely on the information you have given us. You must answer all questions that we ask honestly and with reasonable care. Where we ask you to answer a specific question, the subject matter of the question is material to the risk we are undertaking or the calculation of the premium or both.

If your answers are not true and complete, we may be entitled to void the policy without return of premium, repudiate liability, treat the policy as if it had been entered on different terms, or limit the amount paid on foot of the contract of insurance.

You must tell us all relevant information when answering the questions asked. This includes disclosing tobacco consumption or use of nicotine replacement products including e-cigarettes. If you are not sure whether something is relevant to the questions asked, you should tell us anyway. We may also contact you if we need to ask you for further information on your answers or as part of any subsequent claim. We will rely on what you tell us and we will not automatically clarify or confirm any information you provide with your GP.

You can address any highly confidential information to Irish Life's Underwriting Team in a sealed envelope with your name, date of birth and application number (if applicable). You must refer to this information when answering your health questions.

If your answers to any of the questions in this application form change between the date you apply for cover and the date your application is accepted, you must let us know immediately as failure to do this may result in a claim being refused.

Genetic Test Information:

You should not tell us about any genetic test (that is, any analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. You must however, where required by our questions, tell us if you are having treatment for or experiencing symptoms of, a genetic condition. You will be asked for information about your family history, including all genetic conditions.

Consent to Automated Decisions, including Profiling:

I agree to automated underwriting decisions being made about me based on set risk criteria and using my personal information, including personal health information. I understand this will make my application process quicker and that the automation is designed to reduce costs, improve efficiency, quality and consistency in underwriting decisions. I understand that I have the right to withdraw such consent at any time by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. I also understand that I have the right to object and to request that a person review and make the final underwriting decision which may also be done by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team.

Life Assured 1

I agree

I don't agree

Life Assured 2

I agree

I don't agree

If you answer 'Yes' to any of the health questions, please give us full details including dates, investigations, results, diagnosis, symptoms and any follow up done or planned in the Medical Details - Other Medical Evidence section below

Please specify what do you smoke and how many/much a day below

A Non-smoker has not smoked or used any nicotine replacement products or E-cigarettes in the last 12 months
It is our practice to carry out occasional tests to confirm smoker status

One alcoholic drink is a pint of beer, a glass of wine or one measure of spirits.

Medical and Other Information (continued)...

	First Person		Second Person	
(1). Please give your height and weight	Feet	Inches	Feet	Inches
	Stones	lbs	Stones	lbs
	OR		OR	
	Cms		Cms	
	Kg		Kg	

	First Person		Second Person	
(2) Which of the following best describes your smoking habits:				
I am a smoker				
I am an occasional smoker or have smoked in the last 12 months				
I have used nicotine replacement products including E-cigarettes in the last 12 months				
I have not smoked or used nicotine replacement products including E-cigarettes in the last 12 months				
I am a life long non smoker				
If selected 'I am a smoker':				
What do you smoke and how many/much a day?	number		number	
	Cigarettes	per day	Cigarettes	per day
	Cigars	per day	Cigars	per day
	Pipe	per day	Pipe	per day

(3). How many alcoholic drinks do you consume in a week? One alcoholic drink is a pint of beer, a glass of wine or one measure of spirits.	None		None	
	Up to 10		Up to 10	
	11 - 20		11 - 20	
	21 - 40		21 - 40	
	41 - 60		41 - 60	
	61 and over		61 and over	

(4). Have you ever had treatment or advice from a doctor, counsellor or health care professional to stop or reduce alcohol?	Yes	No	Yes	No
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(5). In the last 10 years, have you used any recreational drugs? (Including but not limited to Cannabis, Cocaine, Ecstasy, Heroin, amphetamines, non-prescription sedatives, tranquilisers, or anabolic steroids)	Yes	No	Yes	No
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(6). In the last 10 years, has any insurer, including Irish Life offered you special terms - cover at an increased cost or with an exclusion or have you been postponed or declined for life, specified illness or income protection cover or have you made a claim for income protection or specified illness cover?	Yes	No	Yes	No
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(7). In the last 5 years, have you spent more than 3 months outside of the European Union (EU), United Kingdom (UK), United States of America (USA), Canada, New Zealand or Australia?	Yes	No	Yes	No
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Medical and Other Information (continued)...

	First Person		Second Person	
	Yes	No	Yes	No
(8). In the next 2 years , apart from holidays of less than 8 weeks duration , do you intend to travel, live or work outside of the European Union (EU), United Kingdom (UK), United States of America (USA), Canada, New Zealand or Australia?				
(9). The ability to take part in exciting sporting activities has become more popular. Please indicate any/all of the following you participate in: Aviation sports (flying, gliding, parachuting) Climbing/mountaineering Diving Water sports Motorsports (car, bike, boat) Other extreme sports Martial arts or combat sports None of these				

HAVE YOU EVER HAD:

(10). any disease or disorder of the heart (including heart valves) or circulatory system, heart attack, angina, cardiomyopathy, heart murmur, heart surgery or any disease of the arteries or peripheral vascular disease including poor circulation in the legs?	Yes	No	Yes	No
(11). a stroke, transient ischaemic attack (TIA), brain haemorrhage, brain injury, aneurysm or surgery to the blood vessels in your brain or neck?	Yes	No	Yes	No
(12). any form of cancer, tumour or malignant condition, leukaemia, Hodgkin's disease, lymphoma, melanoma, cancer-in-situ, benign brain tumour or any brain or spinal growth or cyst?	Yes	No	Yes	No
(13). any mental health disorder (including bipolar, mood disorder, personality disorder or eating disorder) which has required a hospital admission or to be seen by a psychiatrist or any other mental health services?	Yes	No	Yes	No
(14). multiple sclerosis, optic neuritis, paralysis, Parkinson's disease, Alzheimer's disease, dementia, cerebral palsy, muscular dystrophy, motor neurone disease or any neurological disorder? (a neurological disorder is a disorder which affects the brain, spinal cord or nerves)	Yes	No	Yes	No
(15). a positive hepatitis B or hepatitis C or HIV test or are you waiting for the results of such a test?	Yes	No	Yes	No

IN THE LAST 5 YEARS HAVE YOU:

(16). had high blood pressure, high cholesterol, chest pains, atrial fibrillation, shortness of breath, palpitations or an irregular heart beat?	Yes	No	Yes	No
(17). had diabetes (Type 1, Type 2, pregnancy related), impaired glucose tolerance, sugar in the urine, thyroid problems or goitre?	Yes	No	Yes	No
(18). noticed or had advice or treatment for any cyst, lump or growth or any mole or freckle which has become painful, changed colour or appearance or increased in size or bled, whether seen by a doctor or not?	Yes	No	Yes	No
(19). been diagnosed with or had treatment for asthma, bronchitis, sarcoidosis, emphysema, chronic obstructive pulmonary disorder (COPD), pneumonia, sleep apnoea or had any lung or breathing problems?	Yes	No	Yes	No

Other mental health services include community mental health team (CMHT) out patient community services, day hospital/centre, addiction counsellor, residential unit.

Medical and Other Information (continued)...

	First Person		Second Person	
(20). had symptoms of, investigations or treatment for epilepsy, seizure, fits, fainting, dizziness, or blackouts?	Yes	No	Yes	No
(21). had symptoms of, investigations or treatment for trembling, numbness, pins and needles, loss of feeling or tingling in face, hands or feet or temporary loss of muscle power?	Yes	No	Yes	No
(22). had any symptoms of or treatment for any disorder of your eyes including any visual disturbance, such as double vision or blurred vision or any disorder of your ears including hearing impairment, tinnitus, vertigo, repeated episodes of dizziness or problems with balance?	Yes	No	Yes	No
(23). have you had any disorder of the digestive system, stomach, pancreas, bowel or liver including Crohn's disease, ulcerative colitis, hepatitis, Barrett's oesophagus, polyps, ulcer or any other disorders of the digestive system?	Yes	No	Yes	No
(24). had symptoms of or treatment for abnormalities of your kidney, bladder, prostate or reproductive system including kidney cysts or stones, urinary tract infection or the presence of blood or protein in your urine	Yes	No	Yes	No
(25). had advice, investigations or treatment for any blood disorder including haemochromatosis, anaemia, vitamin B12 deficiency or any other blood or clotting disorder?	Yes	No	Yes	No
(26). had any symptoms, treatment or advice for stress, depression, anxiety, low mood, self harm, chronic fatigue, myalgic encephalomyelitis (M.E.) or fibromyalgia?	Yes	No	Yes	No
(27). had any symptoms of or treatment for: <ul style="list-style-type: none"> any back or neck pain including sciatica, trapped nerves or whiplash, any joint pain or disorder of the knees, hips, ankles, shoulders, elbows or wrists, any type of arthritis or gout, any muscular pains, cartilage, ligament or tendon injuries? 	Yes	No	Yes	No
(28). had or been advised to have a surgical operation or any medical investigation including blood test, CT scan, MRI imaging, scope, X-Ray, biopsy, or have you had an abnormal cervical screening, mammogram or prostate specific antigen (PSA)?	Yes	No	Yes	No
(29). seen or been advised to see any specialist as an in-patient or out-patient at any hospital or clinic or are you under regular review with your GP or specialist for any other illness or condition not already mentioned?	Yes	No	Yes	No
(30). In the last 3 years , have you been unable to work for more than four consecutive weeks at a time?	Yes	No	Yes	No
(31). In the last 3 months have you had any symptoms of ill health for which you have not sought medical advice such as unexplained bleeding, weight loss, change of bowel habit, unexplained lump or growth, breathing problems or shortness of breath, or a cough that's lasted for 4 weeks or more?	Yes	No	Yes	No

You do not need to tell us about Vision corrected by lenses or glasses

You do not need to tell us about broken fingers or toes, c-section, infertility treatment, miscarriage or pregnancy without complications

Maternity, paternity, adoptive, leave or career breaks do not need to be disclosed.

Medical and Other Information (continued)...

	First Person		Second Person	
(32). In the last 3 months:				
• have you tested positive for coronavirus/COVID-19?				
• have you been advised to have a coronavirus/COVID-19 test?				
• are you waiting on a coronavirus/COVID-19 test result?	Yes	No	Yes	No

(33). In the last 30 days:				
• have you experienced symptoms of a new or unexplained continuous cough, a high temperature or fever or breathing difficulties?				
• have you been advised by a doctor or public health staff to self-isolate due to coronavirus/COVID-19 (excluding mandatory government orders to remain at home)?	Yes	No	Yes	No

(34). Apart from anything you have already told us in the previous answers - are you currently taking or have you been advised to take prescribed drugs, medicines, tablets or any other treatment lasting more than two weeks within the last year?	Yes	No	Yes	No
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(35). Have any of your parents, brothers or sisters ever had any of the following conditions before age 60?	Yes	No	Yes	No
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Heart disease (angina, heart attack, bypass surgery) - Stroke – Cardiomyopathy – Diabetes Type 2 –Cancer (Bowel, Prostate, Breast, Ovarian or other site) Familial Polyposis of the Colon - Polycystic Kidneys - Multiple Sclerosis - Motor Neurone Disease - Parkinson's disease – Dementia/Alzheimer's disease - Muscular Dystrophy - Huntington's disease – Haemochromatosis

First Person		Second Person	
Condition Suffered	Age Started	Condition Suffered	Age Started
Father			
Mother			
Brothers			
Sisters			

(36). Have you undergone or been advised to have any tests or investigations for any disorder which runs in your family? (You should not tell us about any genetic test which you may have had)	Yes	No	Yes	No
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You do not need to tell us about oral contraceptives, over the counter medication for cold/flu or if you have already disclosed your medical condition in a previous answer.

Medical Details – Other Medical Evidence

Is there any other medical evidence you would like to disclose in relation to the specific health questions above?

First Person

Question No

Second Person

Question No

Will there be a Fast Track Questionnaire or any other questionnaires accompanying the application form?	First Person		Second Person	
	Yes	No	Yes	No

Please give the name and address of your doctor.


First Person

Second Person

If you have changed doctor in the last year, please give the name and address of your previous doctor as well.

Information is correct as of 01/07/2021 and is subject to change.

10



11

The trustee will own and is entitled to receive all information on the policy or policies issued by the Life Office in relation to the Scheme. The employer and employee understand and acknowledge that the trustee will process and hold this information for the purposes of issuing and administering all aspects of this contract, including disclosing the data to regulatory authorities, or, as required by law.

The contributions payable towards the assurance or assurances will be contributions made by you (including Additional Voluntary Contributions) and/or the Employer in accordance with the Applications subject always to the Rules.

Please acknowledge receipt of this letter by signing below and returning it to the employer.



Please sign and date

Signature of person duly authorised to sign for and on behalf of the **EMPLOYER**.



Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.

Name of authorised person

Position in company

I acknowledge receipt of this letter and understand the contents hereof. I hereby agree to be included in the scheme.



Please sign and date

Signed **EMPLOYEE**



Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.

B. Revenue Details

Details are required as part of the approval process with the Revenue Commissioners. If there is insufficient space below please attach additional details on a separate sheet.

Does the employee have any pension benefits from current or previous employments
(this information must also be provided where retirement benefits have already been taken)? Yes No

If NO, please go to section C.

If Yes, please complete the rest of this section.

1. Does the employee have Defined Contribution company scheme pension benefits from current or previous employments?

Yes - Current employment Yes - Previous employment No

If Yes to either provide details:

Normal retirement age	Current value (Including AVC / PRSA AVC values)	€	
If current employment	Total employer contributions	€	per annum
	Total employee contributions	€	per annum

Name of Life Office

If previous employment

Scheme Name

Name of Life Office

2. Does the employee have Personal Pension/PRSA (including self-employed) pension benefits from current or previous employments?

Yes No

If Yes provide details Current value €

Name of Life Office

3. Does the employee have Defined Benefit Company scheme pension benefits from current or previous employments?

Yes - Current employment

Yes - Previous employment

No

If Yes to either provide details

Normal retirement age

Employee pension payable at NRA

Retirement lump sum (if in addition to pension at NRA)

Spouses pension % / Registered civil partners pension %

€

€

Current value of any AVC / PRSA AVC

€

If current employment

Total employee & AVC contributions

€

per annum

Death benefit

€

Name of Life Office

If previous employment Date of leaving service

Scheme Name

Name of Life Office

4. Have you received retirement benefits from any other pension arrangements?

Yes

No

If Yes provide details

Date benefits were paid?

For Defined Contribution Schemes, PRSA or Personal Pension benefits:

Total value of pension fund at date of payment

€

For Defined Benefit / Public Sector Schemes:

Gross Retirement Lump Sum (before any tax paid):

€

Annual pension income:

€

a year

Final value of AVCs (if not included in the above amounts):

€

Further pension benefit details (if any)

C. Employee/Member Plan Declaration

I understand and agree that information I have provided in the declarations in this form (online or otherwise), Letter of Exchange in this application form, any supplementary questions answered, any statements made to Irish Life in writing or by telephone or any information I give to a medical examiner or nurse acting for Irish Life are material to the decision of Irish Life Assurance PLC (Irish Life) to enter into the contract, on the terms and for the calculation of premium and that Irish Life has relied on this information in so doing. The contract with Irish Life comprises the plan schedule, Letter of Exchange, the terms and conditions booklet and any extra rules Irish Life head office staff may add in writing.

I have read and understand the important information about my obligation to answer all questions asked by Irish Life in connection with the application and I understand that if I do not answer these questions honestly and with reasonable care, Irish Life will be entitled (depending on the breach) to declare the plan void, refuse my claim, treat my insurance as if it was entered on different terms, or reduce my claim. If this happens, I understand and acknowledge there may be no cover under the plan, Irish Life may not refund my premiums and Irish Life may not pay a claim.

I declare that all answers I have provided, including those about tobacco consumption or use of nicotine replacement products including e-cigarettes, are true and complete. I declare that I have answered all of the questions in this form honestly and with reasonable care.

I understand that I must tell Irish Life in writing about any changes in my answers to the specific questions in this application form between the time I applied for cover and the date my application is accepted.

I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment. I acknowledge that a copy of my application will be sent to me and agree to notify Irish Life, in writing, if:

- I do not receive the printed record
- Any answer in this record is false, incorrect or incomplete

I understand that Irish Life can use my personal information for any subsequent applications to Irish Life.

I authorise Irish Life to request and receive my personal health information now (or as part of any claim assessment including after my death) from any health professional who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of processing my application and assessing claims.

- I declare that I have been provided with the necessary information to make an informed investment decision. I am happy with the investment choice made on this application form (or supplied through any additional documents linked to this application).
- I confirm I have read and understood the Medical and Other Important Information section.
- I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.
- I confirm I have read and understood the Plan Declaration



Please sign and date

Signature



Date

Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.

D. Employer Declaration To Irish Life - must be completed in all cases here the employer is the trustee or where an independent trustee has been appointed.

I declare that all the answers to the above questions are answered honestly and with reasonable care. I hereby agree that the contract proposed with Irish Life Assurance plc (Irish Life) comprises of the Letter of Exchange in this application form (including this declaration), together with all the terms and conditions and any extra rules Irish Life head office staff may add in writing.

I have read and understand the important information about my obligation to answer all questions asked by Irish Life in connection with the application and I understand that if I do not answer these questions honestly and with reasonable care, Irish Life will be entitled (depending on the breach) to declare the plan void, refuse any claim, treat the insurance as if it was entered on different terms, or reduce the claim. If this happens, I understand and acknowledge there may be no cover under the plan, Irish Life may not refund my premiums and Irish Life may not pay a claim.

I understand that the product(s) are conditional on the approval of the arrangement by the Revenue Commissioners as an exempt approved scheme under Chapter 1 of Part 30 of the Taxes Consolidation Act 1997.

I acknowledge and I understand and accept that the contract to which this application form and declaration applies is between Irish Life and the parties named on the Letter of Exchange that established this scheme. I confirm that the contract effected in pursuance of this application will be held by the Trustee under irrevocable trust for the purpose of providing retirement and other relevant benefits as defined by Chapter 1, Part 30 of the Taxes Consolidation Act 1997 to or in respect of the employee as set out in the Rules of the Scheme. Irish Life will act on either my (the employer's), the employee's or the trustee's instructions in accordance with the Plan's Terms and Conditions.

S59 of Part VI of the Pensions Act, 1990 as amended, requires that a registered administrator is appointed and I understand that Irish Life are appointed to act as such for this Scheme. By accepting this application, Irish Life agrees to act in accordance with this role (outlined in S64G of Part VIA of the Act). I agree that either Irish Life or the trustee can choose to terminate this appointment by giving at least 90 days written notice to the other party. This 90 day notice period may only be reduced where both parties agree to it, or if required by legislation.

If the employer named on the Letter of Exchange is also appointed as Trustee I acknowledge that I as the trustee am responsible for ensuring that the employee (member) has been/will be provided with all information required by relevant pension's legislation and all information necessary to enable him/her to exercise any discretion allowed under the Scheme Rules in relation to investment choice.

I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.

 Please sign and date

Signature



Duly authorised to sign for and on behalf of the Employer, and as Trustee if relevant

Date

Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.

E. Optional Consent

Consent to Sharing with Other Companies in the Irish Life Group

I agree to Irish Life Assurance sharing my personal information (excluding my personal health information) with other companies within the Irish Life Group, such as Irish Life Health. I understand this is to assist in developing combined customer services (for example, access to services from different Group companies on one online platform). This is an area that will continue to improve with a view to adding new customer engagement offerings.

You can change your mind at any time and opt-out of any further sharing by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. If you opt-out we will keep a record of your instruction to opt-out.

Customer	I agree	I don't agree
Trustee	I agree	I don't agree



Your Irish Life Plan Details

Please complete **all** the fields in this Section

Plan Number(s)

If this mandate is to cover more than 3 plans, please attach separate instructions.

Name of Plan Owner(s)

Direct Debit collection date _____ of the month (1st to 28th only)

Payment frequency Monthly Quarterly Half Yearly Yearly

SEPA DIRECT DEBIT MANDATE

Please complete all the fields below marked * and return this mandate to Irish Life

Name and address of the payer:

* Name(s) of Account Holder(s)

Address of Account Holder(s)

BIC

* IBAN

Your BIC and IBAN can be found on a recent bank statement



Please sign and date

* Signature(s)



* Date of signing

Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.

By signing this mandate form, you authorise (A) Irish Life to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Irish Life. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

For Office Use only

UMR

Creditor Identifier

IE30ZZZ303587

Type of payment

Recurrent ☒

Creditor's name and address

I	R	I	S	H		L	I	F	E		A	S	S	U	R	A	N	C	E		P	L	C					
L	O	W	E	R		A	B	B	E	Y		S	T	R	E	E	T											
D	U	B	L	I	N		1																					