PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

PROTECTION
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.

000174

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.

Product Selection

Please tick which product you require:

Term Life Insurance ◯ Mortgage Life Insurance ◯

Life Long Insurance (Guaranteed Whole of Life) ◯ Income Insurance ◯

Profile Number

Profile

1(a). Personal Details First Person to be Covered

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

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

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

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

Level of Earnings € each year

Address

Mobile Number

Home/Work Number

Email

We are obliged to establish your Nationality to comply with Anti Money Laundering requirements

Nationality

Are you Irish Resident for tax? Yes ◯ No ◯

We are obliged to establish tax residency to comply with Anti Money Laundering requirements

1(b). Personal Details Second Person to be Covered

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

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

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

Smoker ◯ Occasional smoker ◯ Used nicotine replacement products or E-cigarettes ◯ Non Smoker ◯

Previous Surname (if any)

Occupation

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

Level of Earnings € each year

Address

Mobile Number

Home/Work Number

Email

We are obliged to establish your Nationality to comply with Anti Money Laundering requirements

Nationality

Are you Irish Resident for tax? Yes ◯ No ◯

We are obliged to establish tax residency to comply with Anti Money Laundering requirements

1(c). Plan Owner Details

Will the owner of this plan be different from the life/s covered? Yes ◯ No ◯

Plan Owner Title (Mr/Mrs/Ms etc)

Plan Owner First Name

Plan Owner Surname

Date of Birth (dd/mm/yyyy)

Mobile Number

Home/Work Number

Email

We are obliged to establish tax residency to comply with Anti Money Laundering requirements

Nationality

Financial reason for cover

Company Name (if owner is a company)

Plan Owner Address

Is the plan to be issued in trust? Yes ◯ No ◯

1(d). Further Details

Is the application in connection with a mortgage? Yes ◯ No ◯

Is the cover amount required less than or equal to the mortgage amount? Yes ◯ No ◯

Would you like the original plan schedule to be sent to the adviser? Yes ◯ No ◯

This includes: Canada Life Progressive Life

Is the plan being set up under a conversion of an existing Irish Life Plan? Yes ◯ No ◯

If YES you must also complete a TRUST FORM which can be found on Bline or MyBiz

Is the plan under which the conversion is being exercised assigned or held in trust? Yes ◯ No ◯

Please provide Plan Number or Group Scheme name/number Under which the conversion is being exercised

Plan number

Group Scheme name/number

Please complete only one of the options (A,B,C or D) in section 2 based on the type of life cover you need

2(a). Term Life Insurance

Term of Cover (years)

	First Person	Second Person
Maximum Life Cover term is to age 85 — Amount of Life Cover you want, if any	€	€
The amount of Accelerated Specified Illness Cover you choose cannot exceed your Life Cover amount — Amount of Specified Illness Cover you want, if any	€	€
If you have chosen Specified Illness Cover which type do you want?	Accelerated ◯ Independent ◯ Standalone ◯	Accelerated ◯ Independent ◯ Standalone ◯
If you choose Hospital Cash Cover you must buy at least €25,000 of Life Cover — Do you want Hospital Cash Cover (HCC)?	Yes ◯ No ◯	Yes ◯ No ◯
MIN €70 per day MAX €260 per day — If YES, how much do you want each day?	€	€
Refer to Ask Underwriting for occupation class for HCC/AC — If YES, what is your Occupation Class?	A ◯ B ◯	A ◯ B ◯
If you choose Accident Cover you must buy at least €25,000 of Life Cover — Do you want Accident Cover (AC)?	Yes ◯ No ◯	Yes ◯ No ◯
MIN €120 per week MAX €400 per week — If YES, how much do you want each week?	€	€
If you have chosen Accident Cover what is your Occupation Class?	X ◯ Y ◯	X ◯ Y ◯
Do you want Inflation Protection (indexation)?	Yes ◯ No ◯	
You can only take out Guaranteed Cover Again if you are under 65 — Do you want Guaranteed Cover Again?	Yes ◯ No ◯	

Guaranteed Cover Again is subject to a maximum of €5 million on Life Cover and €1 million on Specified Illness Cover.

2(b). Mortgage Life Insurance

The maximum term for cover is 50 years. Maximum Life Cover term is to age 85.

Term of Cover (years)

Initial Amount of Life Cover you want €

Maximum term for Specified Illness Cover is to age 75. The amount of Specified Illness Cover you choose can be different to your level of Life Cover but cannot exceed it.

Initial Amount of Specified Illness Cover you want, if any €

Do you want Guaranteed Cover Again? Yes ◯ No ◯

Guaranteed Cover Again is subject to a maximum of €5 million on Life Cover and €1 million on Specified Illness Cover.

2(c). Life Long Insurance (Guaranteed Whole of Life)

This plan type gives you life cover for your whole life. It never generates a cash value.

PLEASE NOTE: If you are using Life Long Insurance for inheritance planning – do not use this form. Please use the Life Long Insurance (Section 72) Inheritance Planning application form along with accompanying Trust forms, which can be found on Bline or MyBiz

Cover Type and Amount (please select one)

	First Person	Second Person
Single	€	
Dual	€	€

Joint Life First Death — **Both Lives** — € _____

Joint Life Last Survivor — **Both Lives** — € _____

Do you want Inflation Protection (indexation)? Yes ◯ No ◯

2(d). Income Insurance

Which Income Insurance Option do you want? Guaranteed ◯ Reviewable ◯

Annual amount of Incapacity Benefit you want? € _____

This will be paid after how many weeks of continuous incapacity 13 ◯ 26 ◯ 52 ◯

This cover will continue until you reach age 55 ◯ 60 ◯ 65 ◯

If you have a claim, do you want your benefit to increase yearly (escalation) Yes ◯ No ◯

Do you want inflation protection (indexation)? Yes ◯ No ◯

Is this a Company Income Insurance plan? Yes ◯ No ◯

If Yes, do you want Pension Payment Protection? Yes ◯ No ◯ Pension Plan Number _____

Refer to Ask Underwriting for occupation class for Income Insurance

Occupation rates at which we work out payments 1 ◯ 2 ◯ 3 ◯ 4 ◯

Are you entitled to State Disability Benefit? Yes ◯ No ◯

This includes: Canada Life Progressive Life

Do you currently have existing Income Insurance with Irish Life or any other Life Office? Yes ◯ No ◯

If answered YES please complete the section below

Please refer to the product booklet for more information. If you choose the reviewable Income Protector option we will review the rates we charge after the first 5 years. The following warning therefore applies:

Insurer _____

If yes, amount of existing cover? € _____

Are you continuing with this cover? Yes ◯ No ◯

Warning: The current premium may increase after year 5

3. 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 ◯

4. Communications and Transactions

Assuming the plan owner is not different from the persons covered and the plan is not to be assigned or written in trust, please confirm who can authorise transactions

All Plan Owners ◯ Only Any Plan Owner ◯ First Person Covered ◯ Second Person Covered ◯

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.

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

First Person Covered	◯ Online	◯ By Paper Post
Second Person Covered	◯ Online	◯ By Paper Post
Plan Owner	◯ Online	◯ By Paper Post

Plan Schedule by post everything else electronically Yes ◯ No ◯

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

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

Are you or any of the Beneficiaries, Trustees, Settlors, 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 ◯

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 Important 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

Medical and Other Information *(continued)...*

	First Person	Second Person
(1). Please give your height and weight Female: If you're expecting a baby, please give weight before pregnancy.	☐ Feet ☐ Inches ☐ Stones ☐ lbs OR ☐ Cms ☐ Kg	☐ Feet ☐ Inches ☐ Stones ☐ lbs OR ☐ Cms ☐ Kg

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

(2) **Which of the following best describes your smoking habits:**	First Person	Second Person
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?

	First Person **number**	Second Person **number**
Cigarettes	◯ ☐ per day	◯ ☐ per day
Cigars	◯ ☐ per day	◯ ☐ per day
Pipe	◯ ☐ per day	◯ ☐ per day

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

(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.	First Person	Second Person
None	◯	◯
Up to 10	◯	◯
11 - 20	◯	◯
21 - 40	◯	◯
41 - 60	◯	◯
61 and over	◯	◯

	First Person	Second Person
(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 ◯
(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 ◯

(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?

First Person	Second Person
Yes ◯ No ◯	Yes ◯ No ◯

(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?

First Person	Second Person
Yes ◯ No ◯	Yes ◯ No ◯

Medical and Other Information *(continued)…*

	First Person		Second Person	
(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?	Yes ◯	No ◯	Yes ◯	No ◯

(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:

	First Person		Second Person	
(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 ◯

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

IN THE LAST 5 YEARS HAVE YOU:

	First Person		Second Person	
(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 ◯

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 ◯
You do not need to tell us about Vision corrected by lenses or glasses (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: • 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 ◯
You do not need to tell us about broken fingers or toes, c-section, infertility treatment, miscarriage or pregnancy without complications (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 ◯
Maternity, paternity, adoptive, leave or career breaks do not need to be disclosed. (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 ◯

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 ◯
(35). **Have any of your parents, brothers or sisters ever had any of the following conditions before age 60?**	Yes ◯	No ◯	Yes ◯	No ◯

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.

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 ◯

Only to be completed for Income Insurance

Other questions for Income Insurance

a). Are you self employed?	Yes ◯	No ◯
b). Do you work more than 50 hours in an average working week?	Yes ◯	No ◯
c). Does your job involve business driving (not including commuting) of more than 20,000 Kms per annum?	Yes ◯	No ◯
d). Do you work at heights in excess of 30 Feet?	Yes ◯	No ◯
e). Do you work offshore or underground?	Yes ◯	No ◯
f). Does your occupation require you to spend more than 50% of your time performing manual work (physical mobility, lifting or carrying)?	Yes ◯	No ◯

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.

Irish Life

PROTECTION PLAN

DECLARATIONS

000173

Proposal Number:

Customer Review Number

Name Life Assured 1

Name Life Assured 2

Financial Adviser Name

If you submit this proposal electronically you should only send us this section.

Any words in the singular also mean the plural as applicable (e.g. "I" means "we" and "my" means "our" etc.)

A. Declaration under regulation 6(3) of the Life Assurance (Provision of Information) Regulations 2001

WARNING

If you propose to take out this plan in complete or partial replacement of an existing plan, please take special care to satisfy yourself that this plan meets your needs. In particular, please make sure you are aware of the financial consequences of replacing your existing plan. If you are in doubt about this, please contact your insurer or insurance adviser.

Please complete this section by ticking the appropriate box:

This includes: Canada Life Progressive Life

- Yes, this plan is replacing an Irish Life plan ○
- Yes, this plan is replacing a plan from another life company ○
- No, this plan is not replacing another plan ○

Existing Plan Number

Declaration of Insurer/Financial Adviser

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001

(Customer name and address)

has been provided with the information specified in Schedule 1 (Customer Information Notice) to those Regulations and that I have advised the customer as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement.

Please sign and date

Signature of Financial Adviser ✗

Date (dd/mm/yyyy)

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

Declaration of Customer:

I confirm that I have received in writing the information specified in the above declaration.

SIGN HERE
Please note that if you are signing on behalf of a company you should precede your signature with "for and on behalf of 'company name'..."

Plan Owner 1 ✗ _____ Plan Owner 2 ✗ _____

Date (dd/mm/yyyy) _____ Date (dd/mm/yyyy) _____

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

B. Plan Declaration

I understand and agree that information I have provided in the declarations in this form (online or otherwise), 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. My contract with Irish Life comprises the plan schedule, 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 GPs, consultants, hospitals or other health professionals 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 confirm I have read and understood the Medical and Other Important Information section.
- I confirm I have received the product booklet and Customer Information Notice.
- I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.

Declaration of Customer(s)

I have read and understood the Plan Declaration and have also received the product booklet.

SIGN HERE
Please note that if you are signing on behalf of a company you should precede your signature with "for and on behalf of 'company name'..."

Plan Owner 1 ✗ _____ Plan Owner 2 ✗ _____

Date (dd/mm/yyyy) _____ Date (dd/mm/yyyy) _____

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

If different from above:

Please sign and date

Life Assured 1 ✗ _____ Plan Owner 2 ✗ _____

Date (dd/mm/yyyy) _____ Date (dd/mm/yyyy) _____

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

C. 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.

Plan Owner 1	I agree ◯	I don't agree ◯
Plan Owner 2	I agree ◯	I don't agree ◯

If different to Plan Owner

Life Assured 1	I agree ◯	I don't agree ◯
Life Assured 2	I agree ◯	I don't agree ◯

Irish Life

000012

Your Irish Life Plan Details

Please complete <u>all</u> 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 IE30ZZZ30358 7

Type of payment Recurrent ✔

Creditor's name and address

IRISH LIFE ASSURANCE PLC
LOWER ABBEY STREET
DUBLIN 1