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.

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.

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

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

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

Home/Work Number

Email

Nationality

Are you Irish Resident for tax? Yes ◯ No ◯

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

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

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

Email

Nationality

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

Are you Irish Resident for tax? Yes ◯ No ◯

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

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

Email

Nationality

Insurable interest / Reason for Cover

Company Name (if owner is a company)

Plan Owner Address

Is the plan to be issued in trust? 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

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

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 ◯

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) ☐☐

Maximum Life Cover term is to age 85

The amount of Accelerated Specified Illness Cover you choose cannot exceed your Life Cover amount

	First Person	Second Person
Amount of Life Cover you want, if any	€	€
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

MIN €70 per day MAX €260 per day

Refer to Ask Underwriting for occupation class for HCC/AC

	First Person	Second Person
Do you want Hospital Cash Cover (HCC)?	Yes ◯ No ◯	Yes ◯ No ◯
If YES, how much do you want each day?	€	€
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

MIN €120 per week MAX €400 per week

	First Person	Second Person
Do you want Accident Cover (AC)?	Yes ◯ No ◯	Yes ◯ No ◯
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.

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.

Term of Cover (years) ☐☐

Initial Amount of Life Cover you want €

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.

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

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

Cover Type and Amount (please select one)

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

	First Person	
Single	€	
	First Person	**Second Person**
Dual	€	€
	Both Lives	
Joint Life First Death	€	
	Both Lives	
Joint Life Last Survivor	€	

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

Insurer

If yes, amount of existing cover? €

Are you continuing with this cover? Yes ◯ No ◯

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:

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 ◯

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

Irish Life

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 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 will 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.

Material Facts:

You must tell us all relevant information when answering all of the questions. If you do not, or if any answers are not true and complete, we could treat the plan as void. This includes disclosing tobacco consumption or use of nicotine replacement products including e-cigarettes. If you fail to reveal all material facts there will be no cover under the plan, we will not refund the payments and we will not pay a claim.

A material fact (relevant information) includes anything that would likely influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the section 'Other medical evidence'. 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.

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 health, circumstances, or 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, tell us if you are having treatment for, or experiencing symptoms of, a genetic condition. You will be asked for full 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 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.

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

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

	First Person	Second Person
(1). Please give the name and address of your doctor.		
If you have changed doctor in the last year, please give the name and address of your previous doctor as well.		

	First Person	Second Person
(2). Please give your height and weight	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

(3). **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.

(4). Typically, how many alcoholic drinks do you consume in a week?	First Person	Second Person
None	○	○
1 - 10	○	○
11 - 20	○	○
20 - 40	○	○
40 - 60	○	○
Over 60	○	○

(5). Have you ever had treatment or advice from a health professional in relation to stopping or reducing your alcohol consumption?

Yes ○ No ○ Yes ○ No ○

Diabetes includes Type 2 diabetes treated by diet, gestational diabetes or Sugar in urine

(6). Have you ever had diabetes (type 1 or 2 or pregnancy related) or sugar in the urine?

Yes ○ No ○ Yes ○ No ○

Medical and Other Information *(continued)…*

	Question	First Person		Second Person	
(7).	Have you ever had any disease or disorder of the heart, including angina, heart attack, bypass, cardiomyopathy, heart valve disorder or heart murmur?	Yes ◯	No ◯	Yes ◯	No ◯
(8).	Have you ever had a stroke, brain haemorrhage or brain injury, transient ischaemic attack(TIA), aneurysm, or any disease of the arteries or veins, including poor circulation in the legs?	Yes ◯	No ◯	Yes ◯	No ◯
(9).	Have you ever had treatment or advice for any form of cancer or malignant condition, leukaemia, Hodgkins disease, lymphoma, melanoma, or a benign brain or spinal tumour?	Yes ◯	No ◯	Yes ◯	No ◯
(10).	Have you ever had symptoms of or had treatment for epilepsy (including seizures, fits or blackouts), multiple sclerosis, optic neuritis, paralysis or any neurological condition?	Yes ◯	No ◯	Yes ◯	No ◯
(11).	Have you ever had symptoms of, treatment or investigations for trembling, numbness, loss of feeling or tingling in face, hands or feet or temporary loss of muscle power?	Yes ◯	No ◯	Yes ◯	No ◯
(12).	Have you ever had symptoms of or treatment for any disorder of the stomach, liver, pancreas or bowel (including Crohn's disease, ulcerative colitis, polyps or ulcer)?	Yes ◯	No ◯	Yes ◯	No ◯
(13).	Have you ever had symptoms, treatment or advice for or been referred for any mental health problems including depression, self harm or psychiatric disorders including bipolar, mood or eating disorders?	Yes ◯	No ◯	Yes ◯	No ◯
(14).	Have you ever taken drugs for other than medicinal purposes, including the use of recreational drugs?	Yes ◯	No ◯	Yes ◯	No ◯
(15).	Have you ever tested positive for Hepatitis B or Hepatitis C, HIV or are you waiting for the results of such tests?	Yes ◯	No ◯	Yes ◯	No ◯
(16).	Are you currently taking or have you been advised to take prescribed drugs, medicines or tablets, creams, inhalers, drops or sprays or have you taken such a course lasting more than two weeks within the past year?	Yes ◯	No ◯	Yes ◯	No ◯
(17).	Within the past five years have you been diagnosed with or had treatment for high blood pressure, high cholesterol, chest pains, an irregular heart beat or any blood disorder including haemochromatosis or anaemia?	Yes ◯	No ◯	Yes ◯	No ◯
(18).	Within the past five years have you had symptoms or had treatment for asthma, bronchitis, sarcoidosis, emphysema or any other disorder of the lungs or airways?	Yes ◯	No ◯	Yes ◯	No ◯
(19).	Within the past five years have you noticed or had symptoms, treatment or advice for any cyst or lump including breast lump or cyst, an abnormal cervical smear, an abnormal mole or a growth whether seen by a doctor or not?	Yes ◯	No ◯	Yes ◯	No ◯
(20).	Within the past five years have you had symptoms of or treatment for any kidney, bladder, urinary disorder (including blood/protein in urine) or prostate disorder (including raised PSA level)?	Yes ◯	No ◯	Yes ◯	No ◯
(21).	Within the past five years have you had any symptoms of or treatment for any disorder of eyes (including any visual disturbance of the eyes, such as double vision or blurred vision) or the ears (including hearing impairiment or loss of balance)?	Yes ◯	No ◯	Yes ◯	No ◯

Vision corrected by lens can be ommitted

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

	First Person		Second Person	
(22). Within the past five years have you had any symptoms of, or required 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 ◯
(23). Within the past five years have you had any symptoms, treatment or advice for stress, anxiety, low mood, chronic fatigue or fibromyalgia?	Yes ◯	No ◯	Yes ◯	No ◯
(24). Within the past five years, have you seen or been advised to see any specialist as an in-patient or out-patient at any hospital or clinic for any other illness or condition not already mentioned?	Yes ◯	No ◯	Yes ◯	No ◯
(25). Within the past five years have you undergone or been advised to undergo any medical investigation including blood test, scan, imaging and x-ray or to have a surgical operation?	Yes ◯	No ◯	Yes ◯	No ◯
(26). Within the past three years have you been unable to work for more than four consecutive weeks at a time?	Yes ◯	No ◯	Yes ◯	No ◯
(27). Do you take part in or have any intention of taking part in any kind of hazardous leisure activity (including private flying, motor sports, mountaineering or scuba diving etc)?	Yes ◯	No ◯	Yes ◯	No ◯
(28). Have you any intention of living or travelling outside of the EU, other than for holidays of less than 8 weeks duration, or have you resided out of the EU, North America, Australia or New Zealand for longer than one year in the last 10 years?	Yes ◯	No ◯	Yes ◯	No ◯
(29). Have you ever been offered specical terms, postponed or declined for life cover, income protection or specified illness cover or have you made a claim for income protection or specified illness cover?	Yes ◯	No ◯	Yes ◯	No ◯
(30). Have any of your parents, brothers or sisters ever had any of the following conditions before age 60?	Yes ◯	No ◯	Yes ◯	No ◯

Failure to disclose a family history could result in a potential claim being refused.

Angina - Heart Attack - Bypass surgery - Angioplasty - Cardiomyopathy - Stroke - Diabetes - Cancer (Bowel, Breast, Ovarian or other site) - Familial Polyposis of the Colon - Polycystic Kidneys - Multiple Sclerosis - Motor Neurone Disease - Parkinson's - Alzheimer's - Dementia - Muscular Dystrophy - Huntington's.

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

Only to be completed for Income Insurance

Other questions for Income Insurance

If YES please provide the percentage of the average working week you spend on each activity

a). Do any of the following form an essential part of your work?

Manual Work Yes ◯ No ◯ % of time at manual work

Driving Yes ◯ No ◯ % of time driving

Average weekly business driving - kms (excluding commuting to work)

Using Machinery or Tools Yes ◯ No ◯ % of time using machinery or tools

Working at heights Yes ◯ No ◯ % of time working at heights

What is the average height you work at? Metres

Do you work more than 50 hours in an average working week? Yes ◯ No ◯

Number of hours worked in average week?

b). What is the exact nature of the occupation from which you receive your earnings? Please provide full details of duties and the % of time spent at each duty

c). Are you self employed? Yes ◯ No ◯

If yes, please say for how long Yrs/months Years Months

d). Have you ever received compensation or made an insurance claim for injury? Yes ◯ No ◯

If yes, please give details

Medical Details – Other Medical Evidence

Is there any other medical evidence you would like to disclose in relation to the 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 ◯

Information is correct as of 01/05/2018 and is subject to change.

Irish Life Assurance plc is regulated by the Central Bank of Ireland.

Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1. **T**: 01 704 1010 • **F**: 01 704 1900

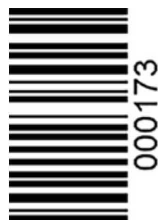
Irish Life

PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

PROTECTION PLAN

DECLARATIONS



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) / /

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 ✗

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

Plan Owner 2 ✗

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

B. Plan Declaration

I understand and agree that my contract with Irish Life Assurance plc (Irish Life) will be based on the declarations in this form, my completed application form (online or otherwise), any supplementary questions answered, any statements made to Irish Life in writing or by telephone, any information I give to a medical examiner acting for Irish Life and all terms and conditions given to me by Irish Life.

I have read and understand the important information about my obligation to tell Irish Life about all material facts in connection with the application and I understand that if I do not tell Irish Life all material facts, this contract could be void. If this happens, I understand and acknowledge there will be no cover under the plan, Irish Life will not refund my premiums and Irish Life will not pay a claim.

I declare that all information, statements and answers I have provided, including those about tobacco consumption or use of nicotine replacement products including e-cigarettes, are true and complete.

I understand that I must tell Irish Life in writing about any changes in my health, circumstances, or any answers to the questions in this application form change 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 information 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 ✗

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

Plan Owner 2 ✗

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

If different from above:

Please sign and date

Life Assured 1 ✗

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

Life Assured 2 ✗

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

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 Assurance plc is regulated by the Central Bank of Ireland.

Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1. **T**: 01 704 1010 • **F**: 01 704 1900

Irish Life

Irish Life

000012

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 / /

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 IRISH LIFE ASSURANCE PLC
LOWER ABBEY STREET
DUBLIN 1