GUARDIAN 1821

DATA CAPTURE FORM

- **THIS IS NOT AN APPLICATION FORM.**

  You should use it only to capture information from your client before you complete and submit an online application on their behalf. During the online application, we may ask you for more information or ask questions not included in this form.

Please make sure your client's aware that you may need to go back to them for further information. You're entering your client's personal and sensitive data in this application. Your terms of business states you have consent from your client to give us their data. Please make sure your client understands we'll handle their data in line with our customer privacy policy. You can refer them to our customer privacy policy on our website.

For more than one person, you'll need to capture details of the second person on a separate form.

We'll give your client a copy of the application form answers you provide, in their welcome pack when the policy goes in force. Please make sure they review this carefully, if anything is wrong they need to let us know within 30 days or they may not be covered.

Please take care when answering the following questions to make sure they're accurate, true and complete. If not, you risk your client's cover being cancelled or when we assess a claim, you risk us paying a reduced amount or nothing at all.

Your client doesn't need to tell us the results of predictive genetic tests unless their existing life cover and application(s) total more than £500,000. Above that limit, your client only needs to tell us the result of genetic tests for Huntington's disease. They can choose to tell us about any negative genetic test result which might enable us to offer better terms.

CLIENT DETAILS

Who needs cover:	
Gender:	☐ Male ☐ Female
Date of birth:	
What best describes your use of tobacco or nicotine replacement products: Tobacco products include cigarettes, cigars, pipes and smokeless tobacco products. Nicotine replacement products include patches, electronic cigarettes, vapes, chewing gum, lozenges, inhalers and sprays.	☐ None in the last 5 years ☐ None in the last 12 months ☐ I have used tobacco or replacement products in the last 12 months.
Height without shoes:	m or ft
Weight in normal indoor clothing:	kg or st
Waist size (males only):	cm or inches
UK dress size (females only):	

CORE COVERS

Life Protection

Cover type: Level ☐ Increasing ☐ Decreasing ☐ Family income ☐

Amount of cover/
Monthly cover amount: _____

Term: _____ years or until age: _____

Life Protection

Cover type: Level ☐ Increasing ☐ Decreasing ☐ Family income ☐

Amount of cover/
Monthly cover amount: _____

Term: _____ years or until age: _____

Life Essentials

Cover type: Level ☐ Increasing ☐ Decreasing ☐

Amount of cover: _____

Term: _____ years or until age: _____

Life Essentials

Cover type: Level ☐ Increasing ☐ Decreasing ☐

Amount of cover: _____

Term: _____ years or until age: _____

Critical Illness Protection

Cover type: Level ☐ Increasing ☐ Decreasing ☐ Family income ☐

Amount of cover/
Monthly cover amount: _____

Term: _____ years or until age: _____

Critical Illness Protection

Cover type: Level ☐ Increasing ☐ Decreasing ☐ Family income ☐

Amount of cover/
Monthly cover amount:

Term: years or until age:

Combined Life and Critical Illness Protection

Cover type: Level ☐ Increasing ☐ Decreasing ☐

Amount of cover:

Term: years or until age:

Combined Life and Critical Illness Protection

Cover type: Level ☐ Increasing ☐ Decreasing ☐

Amount of cover:

Term: years or until age:

Income Protection

Cover type: Level ☐ Increasing ☐

Monthly cover amount:

Term: years or until age:

Deferred period: 4 weeks ☐ 8 weeks ☐ 13 weeks ☐
26 weeks ☐ 52 weeks ☐

Payment period: full-term ☐ 2-year ☐

Income Protection

Cover type: Level ☐ Increasing ☐

Monthly cover amount: _____

Term: _____ years or until age: _____

Deferred period: 4 weeks ☐ 8 weeks ☐ 13 weeks ☐
26 weeks ☐ 52 weeks ☐

Payment period: full-term ☐ 2-year ☐

OPTIONAL COVERS – CAN ONLY BE TAKEN OUT WITH A CORE COVER

Children's Critical Illness Protection

Amount of cover: _____ term _____

Children will stop being covered when they reach their 23rd birthday, or the term ends.

CONTACT DETAILS

Email: _____

We'll use this email address to set up an online account for your client to access their policy details.

Telephone/mobile: _____

Address including postcode: _____

Mortgage cover

Is any of the cover in this application associated to a new or existing mortgage? ☐ Yes ☐ No

Children's details for Children's Critical Illness Protection

We need all children's names and dates of birth so we can advise when children are no longer covered.

Please complete your children's details, or if you are only looking to cover unborn children, please choose 'Cover unborn children only' below.

Child's name:		
Date of birth:		
Child's name:		
Date of birth:		
Child's name:		
Date of birth:		
Child's name:		
Date of birth:		
Cover unborn children only	☐ Yes	

PERSONAL DETAILS

What best describes your use of tobacco or nicotine replacement products?

- ☐ None in the last 5 years
- ☐ None in the last 12 months
- ☐ I've used tobacco or replacement products in the last 12 months

If selected 'I have used tobacco or replacement products in the last 12 months': Have you given up smoking or do you only use nicotine replacement products?

☐ Yes ☐ No

(For current smokers only)
How much do you smoke a day on average? If you use tobacco occasionally or are a social smoker who doesn't smoke every day, please enter 0.

Cigarettes, small cigars or cigarillos		Number per day
Cigars		Number per day
Pipes		Number per day

Tobacco products include cigarettes, cigars, pipes and smokeless tobacco products. Nicotine replacement products include patches, electronic cigarettes, vapes, chewing gum, lozenges, inhalers and sprays.

JOB

What is your job?

This needs to be your main job - in other words, the one you spend most time doing. If you can't find your exact job, try describing your job differently, or pick the closest match.

What are your annual earnings? (Income Protection only)

This is your personal taxable earnings before you pay any income tax, minus any expenses which are allowable against income tax. If you're employed, you'll find this on your P60. If you are self-employed and registered with HM Revenue and Customs, you'll find this on your tax return..

Are you self-employed? ☐ Yes ☐ No (Income Protection only)

This means you run your own business and are not paid through PAYE.

If Yes to the question above:
Have you been self-employed for less than one year? ☐ Yes ☐ No (Income Protection only)

Are you a member of the armed forces or territorial army or reservist? ☐ Yes ☐ No

If Yes to the question above:
Which are you a member of:

☐ Full-time armed forces member

☐ Territorial army or reservist

Please tell us more about your job. Do any of the following apply to you or your unit? ☐ Yes ☐ No

- Currently deployed outside the UK
- Under orders or on notice to move
- Have a state of readiness to deploy within the next 12 months

If you answered Yes to any of these questions then please provide full details here:

Do you have another job? ☐ Yes ☐ No (Income Protection only)

If Yes to the above:
What is your other job?

(Income Protection only)

How many hours a week do you work on your second job? (Income Protection only)

EXISTING COVER

Do you have any existing cover or previous applications with Guardian, or are you in the process of applying (other than this application)?

☐ Yes ☐ No

Answering this question incorrectly may mean we ask for medical evidence, such as a nurse screening, or reducing your cover amount after the policy goes in force.

If Yes to the above question:

Will this new application replace all existing cover you currently have with Guardian?

☐ Yes ☐ No

We won't automatically cancel any existing cover when this policy goes in force. You, or your Financial Adviser, will need to contact us to cancel it. If you've told us the existing cover will be replaced but you don't cancel it, this may impact the amount we pay if you make a claim.

If No to the above question:

What is the total amount of life cover you'll have with Guardian once this application is in force?

What is the total amount of critical illness you'll have with Guardian once this application is in force?

What is the total annual income protection you'll have with Guardian once this application is in force?

Please include the cover amount applied for in this application along with any existing cover with Guardian that won't be replaced. For Family Income Benefit please multiply the annual cover amount by the length of the term to calculate the total cover amount.

You only need to answer the following question if you're applying for life cover in excess of £500,000 or critical illness cover in excess of £250,000.

Together with any existing or concurrent applications will you have more than £1,000,000 critical illness cover in total?

☐ Yes ☐ No

If there is already critical illness cover in place which you are planning to cancel, you don't need to include it. Please include concurrent applications, and any existing critical illness policies that will remain in force.

Together with any existing or concurrent applications will you have more than £5,000,000 life cover in total?

☐ Yes ☐ No

If there is already life cover in place which you are planning to cancel, you don't need to include it. Please include concurrent applications, and any existing life policies that will remain in force.

FAMILY HISTORY

Have any of your natural parents, brothers or sisters, been diagnosed with, or died from, any of the following illnesses, before the age of 65?

Please select all that apply:

Heart attack, angina or stroke (you don't need to tell us about a family history of transient ischaemic attack / TIA):	☐ Yes	☐ No/don't know
Cancer of the breast or ovary (Females only):	☐ Yes	☐ No/don't know
Cancer of the bowel or colon, or polyps of the bowel or colon:	☐ Yes	☐ No/don't know
Diabetes:	☐ Yes	☐ No/don't know
Multiple sclerosis, Parkinson's disease or Alzheimer's disease:	☐ Yes	☐ No/don't know
Muscular dystrophy, myotonic dystrophy, Huntington's disease or motor neurone disease:	☐ Yes	☐ No/don't know
Cardiomyopathy:	☐ Yes	☐ No/don't know
Polycystic kidney disease:	☐ Yes	☐ No/don't know
Any other condition that runs in your family that you've been tested for, are under surveillance for or for which you're having regular follow-up:	☐ Yes	☐ No/don't know

If Yes to the above question:

Please select all the conditions that apply to your relatives:

- ☐ Haemochromatosis
- ☐ Retinitis pigmentosa
- ☐ Friedreich's ataxia
- ☐ Any other cancer
- ☐ Another disorder

If you don't know all your family history, please tell us what you do know. For any question you can't answer because you're adopted, no longer in touch or don't know, please answer 'No / Don't know'.

If they answered Yes to any of these questions then please provide full details here:

MENTAL HEALTH

Have you ever had any mental health condition or illness where hospital treatment or referral to a mental health specialist of any profession has been advised?

Please select all that apply.

Eating disorder:	☐ Yes	☐ No
Bipolar disorder:	☐ Yes	☐ No
Manic depression:	☐ Yes	☐ No
Schizophrenia:	☐ Yes	☐ No
Psychosis:	☐ Yes	☐ No
Borderline personality disorder:	☐ Yes	☐ No
Any other mental health condition or illness:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

A mental health specialist includes a psychiatrist, psychologist or hospital clinic.

If they answered Yes to any of these questions then please provide full details here:

In the last 5 years, have you had?

Please select all that apply.

Depression:	☐ Yes	☐ No
Anxiety:	☐ Yes	☐ No
Stress:	☐ Yes	☐ No
Eating disorder:	☐ Yes	☐ No
Any other mental health condition or illness:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

Please include any condition or illness that involved time off work or treatment, counselling or consultation with a health professional.

If they answered Yes to any of these questions then please provide full details here:

Have you ever?

Please select all that apply.

Tried to take your own life:	☐ Yes	☐ No
Had thoughts about taking your own life:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

If they answered Yes to any of these questions then please provide full details here:

Have you ever?

Please select all that apply.

Intentionally harmed yourself:	☐ Yes	☐ No
Had thoughts about harming yourself:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

If they answered Yes to any of these questions then please provide full details here:

PHYSICAL HEALTH

Have you ever had any of the following?

Please select all that apply.

Cancer, Hodgkin's lymphoma, non-Hodgkin's lymphoma or leukaemia:	☐ Yes	☐ No
Heart attack, heart disorder, angina, heart valve or structural, abnormalities, or cardiomyopathy:	☐ Yes	☐ No
Stroke or transient ischaemic attack (TIA), brain injury, brain haemorrhage, any form of bleeding into your brain or any surgery to your brain:	☐ Yes	☐ No
Diabetes, borderline diabetes, pre-diabetes, impaired glucose tolerance or sugar in the urine:	☐ Yes	☐ No

If Yes to the above question, which of the following do you have?

- ☐ Type 1 or insulin dependent diabetes
- ☐ Type 2 or non-insulin dependent diabetes
- ☐ Gestational diabetes
- ☐ Borderline diabetes or pre-diabetes
- ☐ Impaired glucose tolerance
- ☐ Sugar in the urine
- ☐ Diabetes insipidus
- ☐ None of these / Don't know

Type 1 diabetes is sometimes also called insulin dependent or juvenile onset diabetes. Type 2 diabetes is sometimes also called non-insulin dependent, adult or maturity onset diabetes. Gestational diabetes is also known as pregnancy related diabetes.

A positive test for HIV or hepatitis B or C, or are you waiting for the results of such a test:

☐ Yes ☐ No

If Yes to the above question, please select all that apply:

- ☐ Have had a positive test for HIV

The maximum policy term we can consider for a client with HIV is:
- Life cover – 30-year term or up to age 80 at expiry
- Income Protection – 30-year term or up to age 65 at expiry

- ☐ Have had hepatitis B or C
- ☐ Awaiting results of tests

Epilepsy, multiple sclerosis, muscular dystrophy, cerebral palsy, Parkinson's disease, Alzheimer's disease or dementia:

☐ Yes ☐ No

None of the above:

☐ Yes ☐ No

If they answered Yes to any of these questions then please provide full details here:

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

Please select all that apply.

Raised blood pressure or cholesterol, chest pain, or irregular heart beat:	☐ Yes	☐ No
If Yes to the above question, what condition(s) have you had?	☐ Raised blood pressure	☐ Chest pain
	☐ Raised cholesterol	☐ Irregular heartbeat
Abnormality or disease of the kidneys, bladder, liver or pancreas:	☐ Yes	☐ No
Anaemia, haemophilia, or other blood disorder:	☐ Yes	☐ No
Paralysis, seizures, tremor, loss of balance, loss of feeling, numbness, persistent and/or recurrent tingling or pins and needles:	☐ Yes	☐ No
Crohn's, colitis, IBS, or anything else affecting your stomach, bowel, oesophagus or digestive system:	☐ Yes	☐ No
Asthma, sleep apnoea or anything else affecting your lungs or breathing:	☐ Yes	☐ No
A growth, lump or cyst:	☐ Yes	☐ No
An abnormal cervical smear, abnormal mammogram or other gynaecological condition that has needed more than one consultation (Females only):	☐ Yes	☐ No
Tinnitus, labyrinthitis, or anything else affecting your ears, hearing or balance (Critical Illness Protection and Income Protection only)	☐ Yes	☐ No
Impaired, blurred or double vision, optic neuritis or anything else affecting your eyes (Critical Illness Protection and Income Protection only)	☐ Yes	☐ No

Back pain, slipped disc, sciatica, whiplash or anything else affecting your back, neck or shoulders (Critical Illness Protection and Income Protection only)	☐ Yes	☐ No
Joint pains, arthritis, or any other symptoms affecting the knees, hips, ankles, feet, elbows, wrists or hands (Critical Illness Protection and Income Protection only)	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No
If they answered Yes to any of these questions then please provide full details here:		

GENERAL HEALTH

In the last 5 years have you had?

Continuous, non-specific or recurrent pain:	☐ Yes	☐ No
Chronic fatigue syndrome, or recurrent fatigue or tiredness:	☐ Yes	☐ No
Fibromyalgia:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No
If they answer Yes to any of these questions then please provide full details here:		

Apart from what you've already told us, in the last 3 years have you?

Please select all that apply.

Taken or been prescribed treatment or medication lasting more than 1 month:	☐ Yes	☐ No
Been advised to see a specialist:	☐ Yes	☐ No
Had any tests, including blood tests, scans or investigations:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

You don't need to tell us about antibiotics for one-off chest infections, infertility treatment, pregnancy and terminations.

If they answered Yes to any of these questions then please provide full details here:

CURRENT HEALTH

In the last 3 months have you noticed or become aware of any of the following?

Please select all that apply.

A lump, cyst or swelling, or a mole that's changed in appearance:	☐ Yes	☐ No
Other breast or testicular changes, or skin changes anywhere, including any firmness, hardening or dimpling:	☐ Yes	☐ No
Unexplained bleeding or weight loss:	☐ Yes	☐ No
A cough that has lasted for more than 3 weeks:	☐ Yes	☐ No
A fit or seizure:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

If they answered Yes to any of these questions then please provide full details here:

Apart from what you've already told us, are you currently?

Please select all that apply.

Having or waiting for medical investigations or tests:	☐ Yes	☐ No
Waiting for any form of treatment to start:	☐ Yes	☐ No
Experiencing any new symptoms you're planning to see a medical professional or your GP about:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

If they answered Yes to any of these questions then please provide full details here:

COVID-19

Have you ever?

Please select all that apply.

Been treated at hospital for coronavirus?	☐ Yes	☐ No
Been told you have Long Covid?	☐ Yes	☐ No

The term Long Covid refers to symptoms or effects from coronavirus that last more than 12 weeks.

None of the above:	☐ Yes	☐ No

If they answered Yes to any of these questions then please provide full details here:

LIFESTYLE

How much alcohol do you drink in a typical week? You may need to think back over the last few months to consider what you would normally drink in a week. Please fill in every box.

Pints of beer, lager or cider	☐	Number per week
Standard (175 ml) glasses of wine	☐	Number per week
Large (250ml) glasses of wine	☐	Number per week
Single measures of spirits (25ml pub measure)	☐	Number per week

HABITS

Have you ever?

Please select all that apply

Received advice, treatment or counselling for the use of alcohol, drugs or non-prescribed medication:	☐ Yes	☐ No
Had a blood test as a result of drinking alcohol:	☐ Yes	☐ No
Used recreational drugs other than cannabis:	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

Examples of recreational drugs are cocaine, ecstasy, heroin and methadone or anabolic steroids that were not prescribed by a doctor.

RESIDENCE AND TRAVEL

Are you a UK resident who has lived in the UK for the last 2 years?

☐ Yes ☐ No

If you answer 'no' to this question, we won't be able to proceed with your application.
A UK resident is someone who fulfils the following requirements:

- Their permanent home must be in the UK
- They have a UK bank account
- They have a UK address (not a 'care of' address)

How long have you been registered with a UK doctor?

☐ The last 2 years or more

☐ Less than the last 2 years

☐ I'm not registered with a UK doctor

If you haven't been registered for the last 2 years, we won't be able to proceed with your application. If you're not sure, please check the date you registered with a doctor before answering.

In the last 2 years have you visited, are you currently visiting, or do you intend to visit any doctor outside the UK for medical treatment, investigations or advice?

☐ Yes ☐ No

Have you lived in Africa, Thailand, Russia, Ukraine or the Caribbean for more than 3 months during the last 2 years?

☐ Yes ☐ No

In the next 2 years, are you planning to travel, live or work, outside the European Union (EU), Isle of Man, Channel Islands, Australia or New Zealand?

☐ Yes ☐ No

You don't need to tell us about any holidays of less than 30 days in a year.

SPORTS AND PAST TIMES

Do you currently, or do you intend to, take part in any of the following?

Please select all that apply.

Mountaineering:	☐ Yes	☐ No
Scuba or deep sea diving:	☐ Yes	☐ No
Sailing other than inland:	☐ Yes	☐ No
Flying (other than as a fare-paying passenger):	☐ Yes	☐ No
Motor sports:	☐ Yes	☐ No
Extreme sports (including, but not limited to, bungee or base jumping, canyoning, caving/potholing, white water rafting, extreme mountain biking, martial arts or combat sports):	☐ Yes	☐ No
Professional or semi-professional sport (including, but not limited to, rugby league, rugby union, football):	☐ Yes	☐ No
None of the above:	☐ Yes	☐ No

ACCESS TO MEDICAL REPORTS FROM YOUR CLIENT'S DOCTOR

We may need to ask your client's doctor for medical information about them. This may be to underwrite their application, or to review the answers they gave on their application after the policy has started. When you apply online, we'll ask for their consent under The Access to Medical Reports Act 1988 or The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, whichever is appropriate. If they don't give us consent, you won't be able to proceed with the application.

DOCTOR'S DETAILS

Doctor's name

Surgery name

Address 1

Address 2 (optional)

Address 3 (optional)

Town/city

County (optional)

Postcode

Surgery email (optional)

Surgery phone number

SET-UP

Payout Planner – nominate death beneficiaries

- Giving us beneficiary details means we can pay death benefits quickly after a claim.
- Your client's **cover summary** will include the beneficiaries they nominate today.
- They can update them anytime by calling us.
- They won't be able to choose Payout Planner once you've passed the Payout Planner section in the online application journey.
- You can set up a trust, which overrides Payout Planner, at any time in the future.

Life Protection

Please provide beneficiary details

First name:	Last name:	Date of birth:	Percentage:

☐ By selecting no, I confirm my client doesn't want to use Payout Planner for Life Protection. They understand without Payout Planner, a trust or any other legal alternative, any life payout may be delayed while waiting for probate to be granted.

Life Protection

Please provide beneficiary details

First name:	Last name:	Date of birth:	Percentage:

☐ By ticking this box, I confirm my client doesn't want to use Payout Planner for Life Protection. They understand without Payout Planner, a trust or any other legal alternative, any life payout may be delayed while waiting for probate to be granted.

Life Essentials

Please provide beneficiary details

First name:	Last name:	Date of birth:	Percentage:

☐ By selecting no, I confirm my client doesn't want to use Payout Planner for Life Essentials. They understand without Payout Planner, a trust or any other legal alternative, any life payout may be delayed while waiting for probate to be granted.

Life Essentials

Please provide beneficiary details

First name:	Last name:	Date of birth:	Percentage:

☐ By ticking this box, I confirm my client doesn't want to use Payout Planner for Life Essentials. They understand without Payout Planner, a trust or any other legal alternative, any life payout may be delayed while waiting for probate to be granted.

Combined Life and Critical Illness Protection

Please provide beneficiary details for the life element of this cover. (They can't nominate beneficiaries for the critical illness element of this cover.)

First name:	Last name:	Date of birth:	Percentage:

☐ By ticking this box, I confirm my client doesn't want to use Payout Planner for the life element of Combined Life and Critical Illness Protection. They understand without Payout Planner, a trust or any other legal alternative, their payout could be delayed.

Combined Life and Critical Illness Protection

Please provide beneficiary details for the life element of this cover. (They can't nominate beneficiaries for the critical illness element of this cover.)

First name:	Last name:	Date of birth:	Percentage:

☐ By ticking this box, I confirm my client doesn't want to use Payout Planner for the life element of Combined Life and Critical Illness Protection. They understand without Payout Planner, a trust or any other legal alternative, their payout could be delayed.

Bank details

Name on personal bank account:

Account number:

Sort code: – –

Address including postcode:

Payment details

Preferred collection day: of the month

Start date of the policy:

I confirm the following statements are true

- I have permission from the client to capture their bank details
- The client is the account holder and they are the only person required to authorise debits on the account.
- I have explained to the client that these bank details will be provided and used to set up the direct debit, and for the required credit fraud and financial crime checks.

ADVICE

Did you give advice on this policy? Yes No

MORE INFORMATION

Guardian Financial Services Limited is an appointed representative of Scottish Friendly Assurance Society Limited. All products are provided by Scottish Friendly.