

LifePlan

Application



This *Application Form* should be read in conjunction with the current *LifePlan Brochure* and *Key Features*.

A copy of the completed *Application Form* and *Terms and Conditions* are available on request. If there is any doubt as to the relevance of any fact it should be included on the *Application Form*, as it is important that all information is fully disclosed. If more space is required please continue on a separate sheet of paper and ensure it is signed and dated by each applicant and/or each life assured.

U.S. Specified Person means a U.S. citizen or tax resident individual, who either holds a U.S. Passport, a U.S. Green Card, has a U.S. residential/correspondence address or who was born in the U.S. and has not yet renounced their U.S. citizenship. More information on U.S. FATCA can be found at www.irs.gov/Businesses/Corporations/Foreign-Account-Tax-Compliance-Act-FATCA.

PLEASE NOTE THAT INSUFFICIENT DETAILS MAY DELAY PROCESSING AND ACCEPTANCE

The Insurance (Anti-Money Laundering) Regulations 2008 requires all Isle of Man life companies to “make enquiries as to how an applicant has acquired the monies to be used as premium for, or contribution to, a policy.” This reflects the Isle of Man’s commitment to maintain the highest possible standards of business practice and to counter money laundering and the financing of terrorism.

RL360° has adopted a risk-based approach to meet these regulations, categorising all countries that we will accept business from into 1 of 3 tiers. Each tier has different source of wealth requirements. We have categorised countries according to their level of compliance with international regulatory standards.

Full details on the source of wealth procedures can be obtained from your financial adviser or can alternatively be downloaded from www.rl360.com/sourceofwealth.pdf

RL360 Insurance Company Limited (“the Company”) accepts no responsibility for any payment until it has been received at a registered RL360° office. Provided that no further information is required and subject to acceptance of your application, your policy documents will be issued as soon as possible. In the unlikely event that you have not received your policy documents within 45 days after signing this form, please contact your financial adviser.

Before you return this *Application Form*, please check the following

Please tick:

- Section 1 completed for single/joint applications
- Section 2 completed if single/joint applicant(s)
- Section 3 completed in all cases
- Section 4 optional
- Section 5 completed in all cases
- Section 6 completed in all cases
- Section 7 completed in all cases
- Section 8 completed in all cases
- Section 9 completed in all cases
- Section 10 completed in all cases where any questions are answered 'yes' and further details are required
- Section 11 read in all cases
- Section 12 completed in all cases
- Section 13 completed in all cases
- Section 14 optional
- Section 15 read in all cases
- Source of Wealth (where applicable):

Income from employment - Certified copy of your last three months' payslips, confirmation of your income from your employer, copy of your recent accounts if you are self employed, or equivalent documentation.

Other income or capital - Relevant certified documentation to verify the source of wealth.

Any other source not listed - Relevant certified documentation to verify the source of wealth.

This form is to be submitted with:

- a signed Personalised Illustration along with the standard medical and financial evidence detailed in it
- a completed payment method form, or cheque made payable to RL360 Insurance Company Limited
- a certified copy of an identity document that includes a photograph for each applicant and life assured and evidence of their age
- certified documentary evidence of each applicant's current residential address
- any supplementary forms

Please complete in BLOCK CAPITALS and in black or blue ink throughout.

Section 1 Application details

Please indicate on which basis you are applying (tick one box only)

Individual applicant(s) Trustee applicant Corporate trustee applicant Corporate applicant

Which life assured basis do you require?

Single life Joint life first death Joint life second death Joint life both death

Section 2 Applicant details

If the basis of the application is one of the following:

- trustee applicant
- corporate trustee applicant
- corporate applicant
- children's application

then please ignore this section and complete the *LifePlan Supplementary Application Form* (reference number LP008) or the *LifePlan Children's Plan Application Form* (reference number LP009).

NOTE: All applicants/trustees/directors must also complete, sign and stamp (where applicable) the Declaration in Section 12 of this *Application Form*.

	First applicant	Second applicant (if applicable)
Sex (please tick)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Title (please tick)	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>
	Other (in full) <input type="text"/>	Other (in full) <input type="text"/>
First name(s)	<input type="text"/>	<input type="text"/>
Last name(s)	<input type="text"/>	<input type="text"/>
Date of birth (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Country and place of birth	<input type="text"/>	<input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>
Country of residence for tax purposes	<input type="text"/>	<input type="text"/>
Tax reference number (ie TIN/NI)	<input type="text"/>	<input type="text"/>
Are you a US Specified Person?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Current residential address and postcode (in full)	<input type="text"/>	<input type="text"/>
Country	<input type="text"/>	<input type="text"/>
Length of time at current address	Years <input type="text"/> Months <input type="text"/>	Years <input type="text"/> Months <input type="text"/>
Home telephone number	<input type="text"/>	<input type="text"/>
Mobile telephone number	<input type="text"/>	<input type="text"/>
Relationship to first applicant	<input type="text"/>	<input type="text"/>

Section 2 Applicant details continued

Online services

If you wish to access details of your policy online, you must supply us with the following information.

	First applicant	Second applicant (if applicable)
Email address	<input type="text"/>	<input type="text"/>
Password (you will only use this once)	<input type="text"/>	<input type="text"/>
Password hint	<input type="text"/>	<input type="text"/>

Exact occupation and duties

What is your exact occupation?	<input type="text"/>	<input type="text"/>
What is your company name?	<input type="text"/>	<input type="text"/>
What is the nature of your business?	<input type="text"/>	<input type="text"/>

Please state the applicants' combined earned/unearned income from all sources including any bonuses.

Currency

	This year	Last year	Previous year
Earned	<input type="text"/>	<input type="text"/>	<input type="text"/>
Unearned	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you have stated annual unearned income please provide details.

Section 3 Life or lives assured details

There can be up to 2 lives assured on the policy. If either applicant is to be a life assured, please tick the boxes below.

	First applicant	Second applicant (if applicable)
The applicant is also a life assured	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

If the lives assured are different from the applicants please provide their details below.

	First life assured	Second life assured (if applicable)
Sex (please tick)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Title (please tick)	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>
	Other (in full) <input type="text"/>	Other (in full) <input type="text"/>
First name(s)	<input type="text"/>	<input type="text"/>
Last name(s)	<input type="text"/>	<input type="text"/>
Current residential address and postcode (in full)	<input type="text"/>	<input type="text"/>
Country of residence	<input type="text"/>	<input type="text"/>
Telephone number	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	<input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>
Date of birth (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Section 3 Life or lives assured details continued

Exact occupation and duties

	First life assured	Second life assured (if applicable)
What is your exact occupation?	<input type="text"/>	<input type="text"/>
What is your company name?	<input type="text"/>	<input type="text"/>
What is the nature of your business?	<input type="text"/>	<input type="text"/>

Please provide details of each of the life assured's earned/unearned income from all sources including any bonuses.

	First life assured	Second life assured (if applicable)
Currency	<input type="text"/>	<input type="text"/>
Earned	This year <input type="text"/>	This year <input type="text"/>
	Last year <input type="text"/>	Last year <input type="text"/>
	Previous year <input type="text"/>	Previous year <input type="text"/>
Unearned	<input type="text"/>	<input type="text"/>
If you have stated annual unearned income please provide details.	<input type="text"/>	<input type="text"/>

Which of the following do you perform in the course of your work? (Please indicate the % spent in each, and ensure the total adds up to 100%.)

	First life assured	Second life assured (if applicable)
a) Managerial, administration, clerical and meetings?	<input type="text"/> %	<input type="text"/> %
b) Skilled, technical, light manual and supervisory on a shop or factory floor?	<input type="text"/> %	<input type="text"/> %
c) Sales (shop/office based), mobile sales, sales management or sales assistance?	<input type="text"/> %	<input type="text"/> %
d) Manual skilled, light unskilled or factory work, including lifting?	<input type="text"/> %	<input type="text"/> %
e) Unskilled work, heavy manual or heavy lifting?	<input type="text"/> %	<input type="text"/> %
	= 100%	= 100%
How much work is carried out at home?	<input type="text"/> %	<input type="text"/> %
Do you work more than 16 hours per week?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you receive payment from any other occupation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please state other occupation	<input type="text"/>	<input type="text"/>

All applicant(s) and each life assured must sign the Declaration in Section 12 and the following should be submitted to support the application

- Full true certified copy of a current passport or national identity card carrying a photograph for each applicant and life assured.
- Documentary evidence of each applicant's residential address (i.e. original or true certified copy of utility, rates, council tax bill, entry from local telephone directory, extract from electoral roll, current driving licence, state benefit book, tax assessment or a mortgage statement). Documents must be the most recently issued in the case of utility bills etc.

Section 4 Correspondence address

If, for any reason, you want correspondence to be sent to a different address you can provide a correspondence address overleaf. In the interest of the security of your policy, the Company recommends that you carefully select the most reliable addressee and correspondence address and advise the Company via your Financial Adviser of any subsequent change of name and/or address during the course of your policy. However, the Company accepts no responsibility for the consequences of sending correspondence to this address.

Section 4 Correspondence address continued

Correspondence address and postcode

Country

Telephone number

Email address

Section 5 Benefits

Policy currency (only one currency is allowed in each policy) UK Sterling US Dollars Euros Japanese Yen

	First life assured	Second life assured (if applicable)
Amount of primary life cover required	<input type="text"/>	<input type="text"/>
Do you require critical illness cover? (maximum age at entry 59 years attained)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'yes' please state the amount of benefit required	<input type="text"/>	<input type="text"/>
Do you require term life cover?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'yes' please state the amount of benefit required and for what length of time the benefit is required (minimum 5 years, maximum 61 years)	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Do you require term critical illness cover?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'yes', please state amount of benefit required.	<input type="text"/>	<input type="text"/>
Do you require accidental death benefit? (maximum age at entry 59 years attained)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you require waiver of premium benefit? (only available to the single/first life to be insured, maximum age at entry 59 years attained)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Benefit increase option

Yes No If this option is selected, the automatic premium increase option (Section 6 - Premiums) must be chosen such that regular premiums increase by at least the same rate.

Benefit increase can be on a 5% or 10% **simple** basis: 5% annually 10% annually

Children's critical illness cover

Please provide the names (in full) of any eligible children to be covered (only available if critical illness cover has been selected). Please note eligible children must be aged between 1 and 17 (attained) to qualify.

	Child 1	Child 2	Child 3
Full name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Have any of these children suffered from, or received, medical advice or treatment for any disease(s) of the heart, kidneys, brain or nervous system, or any form of cancer, or any other illness apart from minor childhood ailments or do any familial or congenital conditions exist?

Yes No If yes, provide full details in Section 10.

Section 6 Premiums

Premium frequency Monthly Quarterly Half-yearly Yearly

Premium amount

Premium term Whole life
 Fixed term for years

Premium increase option Yes No (This option must be selected if the benefit increase option is selected.)
 If yes, increasing at: 5% annually 10% annually

Section 7 Choice of investment funds

Fund choice

Please list your choice of funds below, up to a maximum of five funds. Please ensure that the percentages invested total 100% and that the amount invested in each fund is not below the GBP25/USD50/EUR50/CHF50/AUD50/JPY5,000 minimum.

ISIN	Fund name	Currency	Percentage of premium
			%
			%
			%
			%
			%
Total			100%

Section 8 Lifestyle details

Please note all questions must be answered in full, any questions answered with "N/A", "-" or "/" are not acceptable. If you answer yes to any question please provide additional information in Section 10.

	First life assured	Second life assured (if applicable)
8.1 Do you currently have an existing policy with us? If yes, please insert your policy number in the appropriate box.	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
8.2 Please state your height	feet <input type="text"/> inches <input type="text"/> cm <input type="text"/>	feet <input type="text"/> inches <input type="text"/> cm <input type="text"/>
8.3 Please state your weight.	pounds <input type="text"/> kg <input type="text"/>	pounds <input type="text"/> kg <input type="text"/>
8.4 In the past 12 months have you used tobacco products (cigarettes, cigar or chewing)? If yes, please state your daily consumption.	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
8.5 Is there any feature of your lifestyle, work or leisure activities or any other circumstances or fact which might affect or threaten your health or life expectancy? If yes, please state full details in Section 10.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8.6 Do you intend to fly, other than as a fare paying passenger on licensed commercial airlines or participate in any hazardous pursuits? For example underwater diving, motor racing? If yes, please complete the supplementary <i>Aviation Questionnaire</i> or other relevant pursuit questionnaire.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 8 Lifestyle details continued

	First life assured		Second life assured (if applicable)	
8.7 Will you be out of your stated country of residence for 30 days or more in any one year? If yes, please state full details of countries to be visited, nature of visit and length of stay in Section 10.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.8 Do you expect or intend to seek a medical opinion within the next 8 weeks? If yes, please state full details in Section 10.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.9 Has any insurer ever declined, postponed or accepted an application on your life on special terms, or have you withdrawn an application? If yes, please state the company(ies), reason(s) and date(s) in Section 10.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.10 Do you have any existing insurance policies (including benefits with RL360 Insurance Company Limited) or are you applying or expecting to apply for insurance benefits with other companies, or do you intend to discontinue any existing cover? Please state the total amount of life and critical illness cover taken out on your life in the last 12 months, including reinstated policies, and the cover currency in Section 10.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current medical attendant (this section MUST be completed)

Please provide details of your usual medical attendant/attending physician below. If you have no usual medical attendant/attending physician, please provide details of the last doctor you consulted and the reason.

	First applicant	Second applicant (if applicable)
Name of doctor	<input type="text"/>	<input type="text"/>
Number of years attended	<input type="text"/>	<input type="text"/>
Address and postcode (in full)	<input type="text"/>	<input type="text"/>
Country	<input type="text"/>	<input type="text"/>
Date of last visit (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Reason for last visit	<input type="text"/>	<input type="text"/>
Results of last visit	<input type="text"/>	<input type="text"/>

(If you require more space, please continue in Section 10.)

Section 9 Medical questions

Please note all questions must be answered in full, any questions answered with "N/A", "-" or "/" are not acceptable. If you answer yes to any question please provide additional information in Section 10.

	First life assured		Second life assured (if applicable)	
9.1 Have you ever been advised to give up tobacco and/or alcohol for any specific reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.2 Have either your drinking or tobacco habits differed in the last five years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.3 Please state the specific amount of your average weekly consumption of alcohol (quantity and type).	beer (in litres) <input type="text"/>	beer (in litres) <input type="text"/>	wine (75cl bottles) <input type="text"/>	wine (75cl bottles) <input type="text"/>
	wine (75cl bottles) <input type="text"/>	wine (75cl bottles) <input type="text"/>	spirits (measures) <input type="text"/>	spirits (measures) <input type="text"/>
	spirits (measures) <input type="text"/>	spirits (measures) <input type="text"/>		

Do you have or have you ever had any of the following?

9.4 Heart or circulatory disorders e.g. high blood pressure, stroke, chest pains, heart murmur, palpitations, rheumatic fever, blood vessel disorders, elevated cholesterol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.5 Respiratory or lung trouble e.g. asthma, bronchitis, persistent cough, tuberculosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.6 Disorders of the digestive system, gall bladder or liver e.g. duodenal ulcer, bleeding from the bowel, hepatitis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.7 Disease or disorder or infection of the kidneys, bladder or reproductive organs e.g. protein or blood in the urine, stones, prostatitis, venereal disease, bilharzia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.8 Nervous, neurological or mental complaint e.g. fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety state, depression?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.9 Ear, eye, nose, throat or skin disorders e.g. ear discharge, defective vision, recurrent tonsillitis, porphyria, psoriasis, dermatitis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.10 Disorders or disease of muscles, bones, joints, limbs or spine e.g. rheumatism, arthritis, gout, slipped disc, other back or neck troubles?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.11 Diabetes, sugar in urine, blood or spleen disorders, thyroid or other glandular disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.12 Cancer, leukaemia, tumour or growth of any kind?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.13 Are any medicines or drugs currently prescribed for you, or are you receiving any medical or psychiatric treatment or advice or awaiting surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.14 Have you received, or do you expect to receive, any advice, counselling, treatment or blood tests in connection with AIDS, HIV or an HIV related disorder or any sexually transmitted disease including hepatitis B?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.15 Have you ever been counselled or treated in connection with alcohol or drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Section 9 Medical questions continued

9.16 Family history

Please provide details of your family history in the table below, including details of their current state of health or, if deceased, the cause of death. Of particular importance is if your father, mother or any brothers or sisters have died or suffered from heart disease, stroke, kidney disease, cancer, multiple sclerosis or diabetes before the age of 65, or suffered from any familial/hereditary disorders.

Please tell us the age at outset if your relative had cancer and the part of the body first affected.

First life assured

Relatives	State of health (or if deceased please state cause of death)	Age (or age at death)
Father	<input type="text"/>	<input type="text"/>
Mother	<input type="text"/>	<input type="text"/>
Brothers (numbers born) <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Sisters (numbers born) <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

Second life assured (if applicable)

Relatives	State of health (or if deceased please state cause of death)	Age (or age at death)
Father	<input type="text"/>	<input type="text"/>
Mother	<input type="text"/>	<input type="text"/>
Brothers (numbers born) <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Sisters (numbers born) <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

If more space is required, please continue in Section 10.

Section 11 Important notes

Your answers to the questions on this form will be used to assess the application and you must, therefore, answer them fully and to the best of your knowledge and belief. You must give us any other information which might be relevant and which could influence our decision. If you are unsure whether a particular fact is relevant, you should disclose it. Protection benefits may be forfeited if relevant information is found to have been withheld. Any policy of insurance issued pursuant to this application may be declared void even if the application has been formally accepted by the Company, where facts which are material to this application have been withheld. In such event, all monies paid may be forfeited. Please give careful consideration to the declaration before signing it.

Before the policy comes into force, any change of facts contained in the answers given in this application must be notified to the Company in writing. The Company reserves the right to amend the terms on which your application may have been accepted or to withdraw acceptance in the event of any such change.

Your application is not binding and no policy will exist until the Company has issued a letter of acceptance, all conditions therein have been complied with and your policy schedule has been issued.

Full details can be obtained by reading the LifePlan *Terms and Conditions* which are available from the Company on request.

Section 12 Declaration

For lives assured

- 12.1 I declare that I have read and understood the important notes within this application and that all the statements made by me, whether in my handwriting or not, are true and complete to the best of my knowledge and belief and I have disclosed all relevant information concerning this application whether or not covered by the questions in this application form or any supplementary questionnaires which might influence the Company's decision concerning this application including whether to assume risk and the amount of premium(s).
- 12.2 I will disclose to the Company any changes to the information given in this application which occur following the completion of this application but prior to the commencement of the policy.
- 12.3 By signing below I irrevocably consent to the Company seeking from any doctor, hospital, medical institution or other person, information which may be related to my occupation, physical or mental health, including the result of any test, and I authorise the giving of such information. This authorisation shall remain in force after my death.

For applicants

- 12.4 I agree that all statements, together with any forms, statements, reports or other information completed or supplied by me or any party on my behalf, shall form the basis of the policy with the Company.
- 12.5 I have read and understood the product *Brochure* and the *Key Features* and fully understand the charges that may be levied.
- 12.6 I agree to accept a policy in the form and containing the standard terms, conditions and rules ordinarily used by the Company for the type of benefits for which I have applied, and the Company shall not be bound in any way by any representations or undertakings made or given by any person save as contained in the policy as issued. It is further agreed and understood that, notwithstanding any statement made to the contrary by any person, no policy comes into existence and no liability whatsoever will attach to the Company as a result of this application unless and until the first premium has been paid and received by the Company and express written notice of acceptance of risk is issued by the Company.
- 12.7 To the best of my knowledge and belief I am not subject to any legislation that would make this application unlawful.
- 12.8 I confirm that on my own initiative I requested and received information about the policy from my financial adviser. On the basis of that information, I hereby apply for this policy. I understand that the policy is offered by the Company which is established in the Isle of Man and as such the Company is subject to the supervisory arrangements of the Isle of Man Government Insurance and Pensions Authority.
- 12.9 I understand that unless I provide a different address for correspondence in Section 4, all correspondence from the Company concerning this application and the policy, if accepted (including acknowledgement of safe receipt by the Company of my premiums, notification of renewal premiums due and of premiums not received by the Company when due) shall be sent to the first named applicant at the permanent address given for that applicant. I remember that any person who is advising me regarding the policy(ies) for which I am applying, is acting for me and not on behalf of the Company.
- 12.10 I will disclose to the Company any changes to the information given in this application which occur following the completion of this application but prior to the commencement of the policy.

Data Protection

Any data you provide to RL360° may be shared, if allowed by law, with other companies both inside and outside of the RL360° Group and to persons who act on your behalf. Data and information about you can be transferred outside of the Isle of Man and RL360° may be required to provide it to its regulator, its government or anyone else required by law. RL360° will use your data and information to allow for the administration of your policy, prevent crime, prosecute criminals and for market research and statistics. RL360° will, at all times, make sure that your data and information is only used in ways that are allowed by law.

The Isle of Man Data Protection Act 2002 allows you, after paying a small fee, to receive a copy of the data and information RL360° holds about you. For further information please write to: Data Protection Officer, RL360°, RL360 House, Cooil Road, Douglas, Isle of Man, IM2 2SP, British Isles.

Section 12 Declaration continued

If the applicant(s) and the life/lives assured are the same people, then please only sign once where the applicant(s) sign.
If the life/lives assured is/are different from the applicant(s) - then all applicant(s) and life/lives assured must sign.

	First applicant	Second applicant (if applicable)
Signed	<input type="text"/>	<input type="text"/>
Date (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
	First life assured	Second life assured (if applicable)
Signed	<input type="text"/>	<input type="text"/>
Date (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Please enter the country where this form was completed and signed:

Section 13 Financial adviser details

This section is to be completed by your financial adviser.
The RL360° adviser number can be obtained from your regional office.

Company name	<input type="text"/>
Adviser number	<input type="text"/>
Name of regulatory or authorising body	<input type="text"/>
Regulatory number (if applicable)	<input type="text"/>
Financial Adviser's stamp (if this does not state an address, please complete company address details too)	<input type="text"/>
Full name	<input type="text"/>
Online services username (if registered)	<input type="text"/>
Work telephone number	<input type="text"/>
Mobile telephone number	<input type="text"/>
Email address	<input type="text"/>

I confirm that I have seen documentary proof of the applicant(s) identity, and certification of their residential address, and have, where applicable, attached suitably certified copies of both as set out in the completion notes, along with this application.

Signed	<input type="text"/>
Date (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>

Section 14 Nomination of beneficiaries

In the event of the death of the life assured on whose death the benefits become payable, as specified in the policy schedule, I hereby (jointly) appoint the beneficiary/ies* named below to receive the benefits (represented by all rights to any proceeds payable under the policy by reason of the death of the life assured) in the percentages stated below absolutely.

	First beneficiary	Second beneficiary
Sex (please tick)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Title (please tick)	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>
	Other (in full) <input style="width: 150px;" type="text"/>	Other (in full) <input style="width: 150px;" type="text"/>
First name(s)	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
Last name(s)	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
Permanent address and postcode (in full)	<input style="width: 150px; height: 40px;" type="text"/>	<input style="width: 150px; height: 40px;" type="text"/>
Country	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
Date of birth (dd/mm/yyyy)	<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 60px;" type="text"/>	<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 60px;" type="text"/>
Percentage of benefit (whole numbers only)	<input style="width: 60px;" type="text"/> %	<input style="width: 60px;" type="text"/> %
	Third beneficiary	Fourth beneficiary
Sex (please tick)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Title (please tick)	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/>
	Other (in full) <input style="width: 150px;" type="text"/>	Other (in full) <input style="width: 150px;" type="text"/>
First name(s)	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
Last name(s)	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
Permanent address and postcode (in full)	<input style="width: 150px; height: 40px;" type="text"/>	<input style="width: 150px; height: 40px;" type="text"/>
Country	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
Date of birth (dd/mm/yyyy)	<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 60px;" type="text"/>	<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 60px;" type="text"/>
Percentage of benefit (whole numbers only)	<input style="width: 60px;" type="text"/> %	<input style="width: 60px;" type="text"/> %

Minor beneficiaries

Where any of the beneficiaries nominated herein has not attained the age of 18 years (notwithstanding that such individual may be in accordance with the law of his or her domicile of full age and the expression 'minor' shall be construed accordingly) then I hereby authorise the Company in its absolute discretion, without seeing the application thereof, to pay the same to any parent or guardian of such minor beneficiary or to apply the same in such manner as may be directed in writing by such parent or guardian and the receipt by such parent or guardian in either case shall be sufficient discharge to the Company for any benefits so paid or applied.

Contingent beneficiaries

The Company does not accept the nomination of contingent beneficiaries and in the event that any of the nominations above shall fail, by reason of the death of a nominated beneficiary/ies before the death of the life assured the benefit payable on the death of the life assured will be payable equally to the remaining beneficiary/ies. If at some point in the future you wish someone else to benefit a new *Nomination of Beneficiary Form* should be completed.

Section 14 Nomination of beneficiaries continued

Important notes

If any of the nominated beneficiaries predeceases the life assured you are advised to review your appointment accordingly and, if necessary, complete a new *Nomination of Beneficiary Form*.

This section must be completed by all applicant(s) who should sign in the presence of two independent witnesses who are not themselves named as potential beneficiaries. One of these witnesses can be your financial adviser. You should all sign whilst together.

It is the responsibility of the applicant(s) to ensure that the nominated beneficiary/ies pursuant to this form will be effective under his or her law of domicile and/or residence. A nomination will not restrict your right to assign a policy. However, any such assignment will automatically revoke the nomination. The effect of the nomination is that upon the death of the life assured on whose death the policy's benefits become payable, those benefits shall be paid to the beneficiary/ies nominated. Where death benefits become payable under a jointly owned policy, the Company will require a signed form of discharge from both the surviving policy owner and the nominated beneficiary/ies.

Declaration

All applicants must sign below in the presence of two independent witnesses who are not themselves named as potential beneficiaries. One of these witnesses can be your financial adviser. You should all sign whilst together.

I hereby declare:

- that the information given by me in this nominated beneficiaries section is true and complete
- that I have read and understood this nominated beneficiaries section and agree to be bound in accordance with its provisions and in accordance with the LifePlan *Terms and Conditions* regarding the appointment of beneficiaries.

Date (dd/mm/yyyy)

	First applicant	Second applicant (if applicable)
Signature (of applicant)	<input type="text"/>	<input type="text"/>
Witnessed by:		
Signature (of witness)	<input type="text"/>	<input type="text"/>
Print name	<input type="text"/>	<input type="text"/>
Address and postcode (in full)	<input type="text"/>	<input type="text"/>
Witnessed by:		
Signature (of witness)	<input type="text"/>	<input type="text"/>
Print name	<input type="text"/>	<input type="text"/>
Address and postcode (in full)	<input type="text"/>	<input type="text"/>

Section 15 Your choice of payment methods

If you wish to pay by credit/debit card, standing order of direct debit, please complete the appropriate payment method form or alternatively, please follow the relevant instructions below.

Cheque

Please send your cheque, made payable to RL360 Insurance Company Limited to RL360°, RL360 House, Cooil Road, Douglas, Isle of Man, IM2 2SP.

Please note that GBP cheques can take up to five working days to clear. Other currency cheques may take considerably longer to clear.

Telegraphic transfer

If you are paying into your policy by telegraphic transfer please instruct your bank to quote your name as a reference.

Please make your payment to RL360 Insurance Company Limited through the appropriate bank below.

Currency	Swift code	IBAN	Sort code	Account number	Bank name	Account name
EUR	CITIGB2L	GB20 CITI 1850 0813 1418 02	18-50-08	13141802	Citibank, London	RL360
GBP	CITIGB2L	GB34 CITI 1850 0813 1420 35	18-50-08	13142035	Citibank, London	RL360
JPY	CITIGB2L	GB26 CITI 1850 0813 1415 00	18-50-08	13141500	Citibank, London	RL360
USD	CITIGB2L	GB54 CITI 1850 0813 1415 78	18-50-08	13141578	Citibank, London	RL360

Bank address

The bank address for all the above accounts is: Citibank, Citigroup Centre, Canada Square, Canary Wharf, London, E14 5LB, UK.



Credit and debit card mandate

Important

We are only able to accept credit or debit cards where the card displays one of the logos above and is prefixed with either a '3', '4' or a '5'.

The maximum amount that can be collected by credit card is GBP99,999.99 (or currency equivalent) per premium.

We cannot accept payments from Rand or Zimbabwe dollar denominated cards.

I authorise you, until further notice in writing, to collect payments as detailed below:

Premium currency (please tick appropriate box) Sterling (GBP) US dollar (USD) Euro (EUR) Japanese yen (JPY)

Premium amount in figures

Premium amount in words

Premium frequency Monthly Quarterly Half-yearly Yearly

Commencing on* (dd/mm/yyyy)

* this applies to initial premium only, future premiums are deducted 2 working days prior to premium due date.

Card type Mastercard/Eurocard Visa JCB American Express*

* The amount we collect from your card will be 1% higher than your premium to cover additional charges applied by American Express.

Card issued by (name of bank)

Country of card issue

Cardholder's name(s) (must be an applicant)

Cardholder's address (as held by the card issuer)

The address details for the cardholder should be the same as the applicant(s) - if not then please provide reasons why in Section 10 of this form.

Card number - - -

Expiry date (mm-yy) -

I understand that RL360 Insurance Company Limited (RL360°) will advise me of the amount to be paid and the dates on which payment is due and that RL360° may only change these after giving me prior notice.

I understand that this authority in favour of RL360° will remain in force until such time as I cancel it in writing to RL360°.

Signature of cardholder(s)

Date (dd/mm/yyyy)

Additional information

In order to comply with the Isle of Man Insurance (Anti-Money Laundering Regulations) 2008, we may require additional source of wealth evidence subject to where the bank that issued your credit or debit card is registered. For further information please refer to our source of wealth information document available online at www.rl360.com/sourceofwealth.pdf.

Any changes to your premiums, including as a result of automatic premium escalation, will be applied without the need for a further instruction.

Standing order instruction

Important

If you wish to change the amount you pay into your policy at a later date, including as a result of automatic premium escalation, you will need to complete a new standing order instruction. If you wish to cancel your standing order you will need to do this directly through your bank.

To the manager	<input type="text"/>	Bank/Building Society
Bank address	<input type="text"/>	
Reference number	<input type="text"/>	

This reference number will be supplied by RL360° after receipt of the application and must be quoted by your bank on all correspondence. Failure to do so may result in payment being rejected by our bankers.

Please debit the payment amount, together with any transfer charges, from my account detailed below:

Currency (please tick appropriate box)	Sterling (GBP) <input type="checkbox"/>	US dollar (USD) <input type="checkbox"/>	Euro (EUR) <input type="checkbox"/>	Japanese yen (JPY) <input type="checkbox"/>
Payment amount in figures	<input type="text"/>			
Payment amount in words	<input type="text"/>			
Payment frequency	Monthly <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Half-yearly <input type="checkbox"/>	Yearly <input type="checkbox"/>
Payment commencement date (dd/mm/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>	until further notice.
Name(s) of account holder(s)	<input type="text"/>			
Branch Swift Code (for all non-GBP and International payments) Swift Code must be either 8 or 11 digits	<input type="text"/>	OR	Bank Sort Code <input type="text"/> - <input type="text"/> - <input type="text"/>	(for UK GBP payments only)
IBAN/Account number (all non-GBP accounts)	<input type="text"/>	OR	Account number <input type="text"/>	(GBP UK Bank only)

Please tick the box in the table below that matches your premium currency.

Tick one	Currency	Swift code	IBAN	Sort code	Account number	Bank name	Account name
<input type="checkbox"/>	EUR	CITIGB2L	GB20 CITI 1850 0813 1418 02	18-50-08	13141802	Citibank, London	RL360
<input type="checkbox"/>	GBP	CITIGB2L	GB34 CITI 1850 0813 1420 35	18-50-08	13142035	Citibank, London	RL360
<input type="checkbox"/>	JPY	CITIGB2L	GB26 CITI 1850 0813 1415 00	18-50-08	13141500	Citibank, London	RL360
<input type="checkbox"/>	USD	CITIGB2L	GB54 CITI 1850 0813 1415 78	18-50-08	13141578	Citibank, London	RL360

Bank address

The bank address for all the above accounts is: Citibank, Citigroup Centre, Canada Square, Canary Wharf, London, E14 5LB, UK.

	Account holder/Authorised Signatory 1	Account holder/Authorised Signatory 2
Signed	<input type="text"/>	<input type="text"/>
Full name	<input type="text"/>	<input type="text"/>
Date (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Instruction to your bank or building society to pay by Direct Debit

Important

Any changes to your premiums, including as a result of automatic premium escalation, will be applied without the need for a further instruction.

Service User Number

Name and full postal address of your bank or building society branch

To the manager Bank/Building Society

Bank address

Name(s) of account holder(s)

Bank sort code (UK only) - - Account number

This Direct Debit Instruction relates to my policy number, reference:

Instruction to your bank or building society

Please pay RL360 Insurance Company Limited Direct Debits from the account detailed in this Instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with RL360 Insurance Company Limited and, if so, details will be passed electronically to my bank/building society.


	Account holder/Authorised Signatory 1	Account holder/Authorised Signatory 2
Signed	<input type="text"/>	<input type="text"/>
Full name	<input type="text"/>	<input type="text"/>
Date (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Banks and building societies may not accept Direct Debit instructions from some types of account

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit, RL360 Insurance Company Limited will notify you 14 working days in advance of your account being debited or as otherwise agreed. If you request RL360 Insurance Company Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit by RL360 Insurance Company Limited or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society - If you receive a refund you are not entitled to, you must pay it back when RL360 Insurance Company Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.



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