

Online Data Capture Form - Broker Life Choice

Please tick (✓) one box only: Life Choice - Home ☐ Life Choice - You & Family ☐ Life Choice - Assets ☐

Important Information

- If you wish to apply for two or more policies a separate Declaration Form **must** be used for each product.
- If you are submitting more than one application at the one time click “Add Product” on the **Product Selection Screen**, and you will only have to enter the client and underwriting details once.

1. Person(s) to be Covered

Please complete in block capitals and tick (✓) where appropriate

First Person to be covered

Title: ☐ Mr ☐ Mrs ☐ Ms Other

First Name:

Surname:

Sex: ☐ Male ☐ Female

Date of Birth: (DD/MM/YYYY)

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Civil Partner
☐ Partner ☐ Co Habitee

Employment Status: ☐ Employee ☐ Self-Employed ☐ Homemaker
☐ Student ☐ Retired ☐ Unemployed

Occupation:

If student please state University/College:

Country of birth:

Country of citizenship:

Length of residency in Ireland: ☐ More than 5 yrs ☐ 2-5 yrs ☐ 1-2 yrs
☐ less than 1 year ☐ not resident

If Not Resident, please state Country of Residence:

Annual Earned Income: €

Consent to seek information from other insurers: ☐ Yes ☐ No

Information means medical and other relevant details given to an insurer by you or any doctor in connection with a life insurance application on your life.

Address:

Second Person to be covered

Title: ☐ Mr ☐ Mrs ☐ Ms Other

First Name:

Surname:

Sex: ☐ Male ☐ Female

Date of Birth: (DD/MM/YYYY)

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Civil Partner
☐ Partner ☐ Co Habitee

Employment Status: ☐ Employee ☐ Self-Employed ☐ Homemaker
☐ Student ☐ Retired ☐ Unemployed

Occupation:

If student please state University/College:

Country of birth:

Country of citizenship:

Length of residency in Ireland: ☐ More than 5 yrs ☐ 2-5 yrs ☐ 1-2 yrs
☐ less than 1 year ☐ not resident

If Not Resident, please state Country of Residence:

Annual Earned Income: €

Consent to seek information from other insurers: ☐ Yes ☐ No

Information means medical and other relevant details given to an insurer by you or any doctor in connection with a life insurance application on your life.

Address:

1. Person(s) to be Covered (Continued)

Contact details

Home phone number:	<input type="text"/>	<input type="text"/>
Work phone number:	<input type="text"/>	<input type="text"/>
Mobile phone number:	<input type="text"/>	<input type="text"/>
Email address:	<input type="text"/>	<input type="text"/>

By providing contact details you are consenting to New Ireland or a duly authorised agent of New Ireland phoning or emailing you if it considers it necessary to obtain further medical or other information relating to your application.

2. Policy Owner(s) (Only complete if different from the Person(s) to be covered)

Owner type - individual(s)

	First Policy owner	Second Policy owner
Title:	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other
First Name:	<input type="text"/>	<input type="text"/>
Surname:	<input type="text"/>	<input type="text"/>
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	<input type="text"/> (DD/MM/YYYY)	<input type="text"/> (DD/MM/YYYY)
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Partner <input type="checkbox"/> Partner <input type="checkbox"/> Co Habitee	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Civil Partner <input type="checkbox"/> Partner <input type="checkbox"/> Co Habitee
Employment Status:	<input type="checkbox"/> Employee <input type="checkbox"/> Self-Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	<input type="checkbox"/> Employee <input type="checkbox"/> Self-Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed
Occupation:	<input type="text"/>	<input type="text"/>
If student please state University/College:	<input type="text"/>	<input type="text"/>
Country of birth:	<input type="text"/>	<input type="text"/>
Country of citizenship:	<input type="text"/>	<input type="text"/>
Length of residency in Ireland:	<input type="checkbox"/> More than 5 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> less than 1 year <input type="checkbox"/> not resident	<input type="checkbox"/> More than 5 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> less than 1 year <input type="checkbox"/> not resident
If Not Resident, please state Country of Residence:	<input type="text"/>	<input type="text"/>
Annual Earned Income:	€ <input type="text"/>	€ <input type="text"/>
Address:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

2. Policy Owner(s) (Continued)

Contact details

Home phone number:	<input type="text"/>	<input type="text"/>
Work phone number:	<input type="text"/>	<input type="text"/>
Mobile phone number:	<input type="text"/>	<input type="text"/>
Email address:	<input type="text"/>	<input type="text"/>

By providing contact details you are consenting to New Ireland or a duly authorised agent of New Ireland phoning or emailing you if it considers it necessary to obtain further medical or other information relating to your application.

Owner type - company

Company Name:	<input type="text"/>
Telephone:	<input type="text"/>
Email address:	<input type="text"/>
For the attention of:	<input type="text"/>
Address	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

By providing contact details you are consenting to New Ireland or a duly authorised agent of New Ireland phoning or emailing you if it considers it necessary to obtain further medical or other information relating to your application.

Name of authorised signatory:	<input type="text"/>
Signatory's job title:	<input type="text"/>
Second authorised signatory:	<input type="text"/>
Second signatory's job title:	<input type="text"/>
Names of Directors:	<input type="text"/>
	<input type="text"/>
Names of Beneficial Owners:	<input type="text"/>
	<input type="text"/>

Where details of two authorised signatories have been provided, New Ireland will act upon instructions from either.

Notes:

- 1) Names of Beneficial Owners with greater than 25% of the capital or profits or more than 25% of the voting rights or who otherwise exercise control.
- 2) If the Company is a public company whose securities are listed on an EU-regulated stock exchange we do not need a list of Directors or the Beneficial Owners.
- 3) We may require evidence of identity and proof of address and other supporting documentation – where this is required we will separately advise you.

Please tick this box if more than 5% of the Company's trading income is from any of the following countries:

☐

Afghanistan, Central African Republic, Cuba, Democratic Republic of the Congo, Eritrea, Guinea-Bissau, Haiti, Iraq, Lebanon, Liberia, Libya, Myanmar, Russia, Somalia, South Sudan, The Bahamas, Yemen.

List the relevant countries:

Please tick this box if more than 5% of the Company's trading income is from any of the following countries:

☐

Iran, Korea North / Democratic People's Republic of Korea, Sudan, Syria.

List the relevant countries:

3. Contract Details

Preferred Policy Start Date: ☐ As soon as possible ☐ To be advised (DD/MM/YYYY)

Reason for cover / insurable interest

Only dates from 1 to 28, inclusive, are permitted.

Please note that if an insurable interest does not exist between the policy owner(s) and person(s) to be covered when the policy is taken out, the policy will be invalid and no claim will be paid. There is no insurable interest between siblings or between parents and their children.

If you have any doubt about the existence or extent of insurable interest please select "Other reason for cover" and give details of reason for cover and what insurable interest exists in the text box below.

- | | |
|--|--|
| <input type="checkbox"/> Mortgage / personal loan cover – own life | <input type="checkbox"/> Mortgage / personal loan cover - joint mortgagees |
| <input type="checkbox"/> Personal cover – own life | <input type="checkbox"/> Personal cover – spouse(s) |
| <input type="checkbox"/> Personal cover – partner(s) | <input type="checkbox"/> Business loan cover - own life |
| <input type="checkbox"/> Business loan cover – joint mortgagees | <input type="checkbox"/> Key person protection cover – employer / employee |
| <input type="checkbox"/> Key person loan cover – employer / employee | <input type="checkbox"/> Company directors / partnership cover – own life |
| <input type="checkbox"/> Company directors / partnership cover – | <input type="checkbox"/> Other reason for cover |

Other reason for cover:

Is the application to be under trust: ☐ Yes ☐ No

Is the application to replace an existing New Ireland policy: ☐ Yes ☐ No

If 'Yes':

Please provide policy number(s) of the case(s) to be replaced:

Are you exercising a conversion option: ☐ Yes ☐ No

(if you are exercising a conversion option, do not complete sections 7 to 11)

Note: It is not possible to cancel assigned policies without the prior written consent of the assignee(s).

4. Cover Details: Life Choice - Home (Mortgage Protection)

(Single or Joint Life)

If you are submitting more than one application at the one time click "Add Product" on the **Product Selection Screen**, and you will only have to enter the client and underwriting details once.

Benefits

Lump Sum on Death	<input type="text" value="€"/>
Term of Cover	<input type="text" value=""/> years
Medical Free Conversion	<input type="checkbox"/> Yes

5. Cover Details: Life Choice - You and Family (Term Assurance)

(Single or Dual Life)

If you are submitting more than one application at the one time click **"Add Product"** on the **Product Selection Screen**, and you will only have to enter the client and underwriting details once.

Benefits

Please select at least one of Lump Sum on Death, Standalone Specified Illness or Income on Death:

	First Person	Second Person
Lump Sum on Death	€ <input type="text"/>	€ <input type="text"/>
Specified Illness	€ <input type="text"/>	€ <input type="text"/>
	<input type="checkbox"/> Accelerated (only available with Lump Sum on Death)	<input type="checkbox"/> Accelerated (only available with Lump Sum on Death)
	<input type="checkbox"/> Additional	<input type="checkbox"/> Additional
	<input type="checkbox"/> Standalone	<input type="checkbox"/> Standalone
Term of Cover	<input type="text"/> years	
Medical Free Conversion	<input type="checkbox"/> Yes	
Increasing Benefits	<input type="checkbox"/> Yes	
(Benefits and Premiums increase at 3% p.a.)		

Income on Death	€ <input type="text"/> per month	€ <input type="text"/> per month
Term of Cover	<input type="text"/> years	

Further optional benefits

Please select optional benefits required:

(These optional benefits will cease on the earlier of

- the person(s) to be covered 65th birthday or
- the longest term of the Lump Sum on Death, Standalone Specified Illness and/or Income on Death benefits)

	First Person	Second Person
Whole of Life Continuation (€10,000 - €50,000) (May only be selected if main benefit term exceeds 10 years)	€ <input type="text"/>	€ <input type="text"/>
Hospitalisation Payment	€ <input type="text"/> per day	€ <input type="text"/> per day
Accident Payment	€ <input type="text"/> per week	€ <input type="text"/> per week
Broken Bones Payment	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Surgery Payment (only available with Specified Illness)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

6. Cover Details: Life Choice - Assets (Business Protection)

(Single or Joint Life)

If you are submitting more than one application at the one time click "Add Product" on the Product Selection Screen, and you will only have to enter the client and underwriting details once.

Benefits

Lump Sum on Death

€

Specified Illness

€

☐ Accelerated* ☐ Additional ☐ Standalone

*only available with Lump Sum on Death

Term of Cover

years

Medical Free Conversion

☐ Yes

Increasing Benefits

☐ Yes

(Benefits and Premiums increase at 3% p.a.)

7. Doctor/Clinic Details

	First Person	Second Person
Do you have a Doctor in Ireland or abroad?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your Doctor details		
Name of Doctor:	<input type="text"/>	<input type="text"/>
Address:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Phone number:	<input type="text"/>	<input type="text"/>
Have you attended any other Doctor (in Ireland or abroad) in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes' please provide further information.

Other Doctor details

Name of Doctor:	<input type="text"/>	<input type="text"/>
Address:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Phone number:	<input type="text"/>	<input type="text"/>

8. Application Method

How are you providing underwriting information for this application?

☐ Online

☐ Teleinterview

Teleinterview

To speed up the processing of your application we strongly recommend you arrange a teleinterview prior to submitting the application to us as this will avoid unnecessary delays in processing your application. This teleinterview will be recorded. You may contact our teleinterview provider on freephone **1800 805395** to arrange a suitable time for your teleinterview. You will be given a reference number which you should record in the field below:

Teleinterview reference number:

First Person

Second Person

Please ensure you have provided at least one telephone number in Section 1.

If you are not in a position to arrange a teleinterview before the application is submitted online we will pass on your personal details to our teleinterview provider who will then contact you to arrange a suitable appointment. Please note that this will likely result in your application taking longer to process.

What is your occupation?

First Person

Second Person

Have you smoked cigarettes, cigars or pipe tobacco in the last 12 months?

☐ Yes

☐ No

☐ Yes

☐ No

9. Personal details (do not complete this section if you are doing a teleinterview)

1. a. Have you smoked cigarettes, cigars, or pipe tobacco in the last 12 months?

☐ Yes ☐ No

☐ Yes ☐ No

b. If "Yes", how much do you smoke each day or if you have stopped smoking in the last 12 months how much did you smoke each day?

Cigarettes per day

Cigarettes per day

Cigars per week

Cigars per week

Pipe tobacco per day

Pipe tobacco per day

2. How much alcohol do you drink each week?

Unit guide: Pint beer = 2.0 units
Bottle beer = 1.5 units Measure spirits = 1.0 units
Bottle wine = 7.0 units Glass wine = 1.0 units

units per week

units per week

3. a. What is your height?

ft ins or cm

ft ins or cm

b. What is your weight?

st lbs or kg

st lbs or kg

10. Occupation Information (do not complete this section if you are doing a teleinterview)

What is your occupation?

First Person

Second Person

Is your occupation 100% administration/supervisory/managerial?

☐ Yes ☐ No

☐ Yes ☐ No

Does your work involve any manual duties?

☐ Yes ☐ No

☐ Yes ☐ No

If yes, give details including % of working week on manual work

Does your occupation involve work at sea, work underground or use of explosives?

☐ Yes ☐ No

☐ Yes ☐ No

If yes, give details including % of working week spent in any of these situations

Do you work at heights above 50 feet?

☐ Yes ☐ No

☐ Yes ☐ No

If yes, what % of your time do you spend working above this height?

%

%

11. Risk Assessment (do not complete this section if you are doing a teleinterview)

For most conditions the **Data Capture Form Medical Conditions** booklet, available in the Literature Library, has the questions that will be asked in the **Drilldown**. Use that booklet as a reference and record the disclosures in this form. This will greatly increase the number of online decisions.

	First person		Second person		First person If "Yes", please complete.	Second person If "Yes", please complete.
	Yes	No	Yes	No		
Medical history details:						
1. Do you currently have or have you ever had any of the following:						
a. heart attack, angina, heart surgery, heart murmur or any other disease or disorder of the heart or arteries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
b. any form of cancer, malignant tumour, Hodgkin's disease, lymphoma, leukaemia or tumour of the brain or spine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
c. stroke, transient ischaemic attack (TIA or mini stroke) or brain haemorrhage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
d. multiple sclerosis, Parkinson's disease, or any other brain or neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
e. paralysis, numbness or tingling in the limbs or face, tremor, temporary loss of muscle power or lack of co-ordination, double / blurred vision or optic neuritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
f. diabetes, thyroid problems, raised blood sugar, glucose intolerance or sugar in the urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
g. hepatitis, other liver disorders, pancreatitis, ulcerative colitis or Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Have you ever had or been referred for treatment or counselling for alcohol excess or misuse, or have you ever been advised by a doctor or other health professional to cease or reduce your alcohol consumption?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Have you ever used any recreational drugs such as cannabis, cocaine, heroin, ecstasy, amphetamines, anabolic steroids or non-prescription sedatives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Have you ever tested positive for HIV or are you awaiting the result of a HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. In the last 5 years have you had, or do you currently have any of the following:						
a. asthma, bronchitis, emphysema or any other lung or breathing disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
b. high blood pressure, raised cholesterol or chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
c. depression, stress, anxiety, eating disorders, chronic fatigue syndrome or other nervous or mental health disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
d. cyst, lump, polyp, growth of any kind, or had or have any mole that has bled, become painful, changed colour or increased in size?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
e. epilepsy, seizure, fit, fainting, dizziness, blackouts, severe headaches or migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
f. back and / or neck disorders including disc problems, sciatica, whiplash, back and / or neck pain or trapped nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
g. arthritis, rheumatoid / psoriatic arthritis, or any knee, shoulder, hip, ankle or other joint disorder or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
h. disorder of the digestive system or stomach including reflux, ulcers, hernia or coeliac disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

11. Risk Assessment (continued)

For most conditions the **Data Capture Form Medical Conditions** booklet, available in the Literature Library, has the questions that will be asked in the **Drilldown**. Use that booklet as a reference and record the disclosures in this form. This will greatly increase the number of online decisions.

	First person		Second person		First person If "Yes", please complete.	Second person If "Yes", please complete.
Medical history details:	Yes	No	Yes	No		
i. disorder of the eyes that is not corrected by spectacles or contact lenses including: impaired vision or blindness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
j. disorder of the ears, nose or throat including: hearing impairment/deafness, tinnitus or vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
k. anaemia, deep vein thrombosis (DVT), haemochromatosis or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
l. – disorder of the kidneys, bladder or prostate? (males only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
– disorder of the kidneys or bladder? (females only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
m. abnormal smear test results, hysterectomy, endometriosis, fibroids, ovarian cysts or mammogram which required further investigation? (females only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Have you had any medical investigations, medical scans, medical tests or surgery within the last 5 years? (You do not need to tell us about normal pregnancy, caesarean section, infertility investigations, dental treatment or tonsillitis/tonsils removed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Are you taking, or have you been advised to take, any prescribed drug(s), medicine(s), tablet(s) or any other treatment(s)? (You do not need to tell us about treatment for colds/flu, hayfever, contraception or infertility)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Are you awaiting any medical referral, medical investigation(s), medical test result(s), surgical procedure or intending to seek medical advice or treatment for any reason (e.g. unexpected weight loss, change in bowel habit, a growth, cyst or lump)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Concerning your family:						
9. Have any of your biological parents, brothers or sisters had any of the following medical conditions before age 60:						
(i) cancer of the breast, ovaries, colon, bowel, rectum, polyposis of the colon or any other form of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) heart attack, angina, heart by-pass, angioplasty, heart failure, cardiomyopathy, stroke, diabetes or haemochromatosis? (You do not need to tell us about a family history of high blood pressure, high cholesterol, hole in the heart or heart valve disorders)						
(iii) multiple sclerosis, Huntington's disease, polycystic kidney disease, motor neurone disease, muscular dystrophy, Parkinson's disease or Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10. Apart from the conditions listed above, have 2 or more of any of your biological parents, brothers or sisters had the same condition before age 60?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

11. Risk Assessment (continued)

If you answered yes to questions 9 or 10, please give details below:

First person

Condition (If cancer, specify the part of the body affected first, eg. bowel) (If heart disease, specify exact nature of heart disease)	Relative	Age at Diagnosis	Details of any check-up/screening (You do not need to disclose any genetic test you may have had)

Second person

Condition (If cancer, specify the part of the body affected first, eg. bowel) (If heart disease, specify exact nature of heart disease)	Relative	Age at Diagnosis	Details of any check-up/screening (You do not need to disclose any genetic test you may have had)

	First person		Second person		First person	Second person	
	Yes	No	Yes	No	If "Yes", please complete.	If "Yes", please complete.	
About your travel and interests:							
11. In the last 10 years, have you spent more than 6 months in total travelling or residing in a country, continent or area other than the European Union (EU), United States of America (USA), Canada, Japan, Singapore, Hong Kong, New Zealand or Australia? If yes, please give details of countries, dates and duration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
12. In the next 12 months, do you intend to travel or reside for more than 60 days in total in a country, continent or area other than the European Union (EU), United States of America (USA), Canada, Japan, Singapore, Hong Kong, New Zealand or Australia? If yes, please give details of countries, dates, duration and purpose.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
13. Do you take part in or intend to take part in any hazardous leisure activities or sports such as scuba diving, motor sports, aviation, water sports, horse riding, martial arts, mountaineering, rock climbing, caving or winter / ice sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Total market cover:							
14. Will your total cover with us or any other insurer (including existing cover, this application and any other application for cover, excluding group risk cover);							
a. exceed the sum of €1,250,000 for life cover?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
b. exceed the sum of €500,000 for specified illness cover? If yes, please give details of each policy/application including type of cover, sum assured, term, insurer, reason for cover and policy start date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

12. To be Completed by the Insurance Intermediary

Option 1: ☐ Option 2: ☐ Option 3: ☐ Option 4: ☐



New Ireland Assurance Company plc.,

11-12 Dawson Street, Dublin 2.

T: (01) 617 2000 F: (01) 617 2075.

E: info@newireland.ie W: www.newireland.ie