

# Life Choice - Policy Change Request Form

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

Advisor's name:

Agency number:

Policy number:

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

This form is to be used to add, remove, increase or decrease a benefit, extend the term of cover or add a person to be covered to an existing policy.

It may also be used if you wish to exercise the Life Events Option or the Medical Free Conversion Option.

Section 1 must be completed in all cases.

Go to section 2 to add a second life to the policy.

Go to section 3 to make changes to your Life Choice - You and Family (Term Assurance) policy.

Go to section 4 to make changes to your Life Choice - Home (Mortgage Protection Assurance) policy.

Go to section 5 to make changes to your Life Choice - Assets (Term Assurance) policy.

## 1. Person(s) currently covered

Please tick (✓) where appropriate.

	First person	Second person
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"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth	DD/MM/YYYY	DD/MM/YYYY
Marital status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner
Gross annual earned income	€ <input type="text"/>	€ <input type="text"/>
Address	<input type="text"/>	<input type="text"/>
Telephone	Home <input type="text"/> Work <input type="text"/> Mobile <input type="text"/>	Home <input type="text"/> Work <input type="text"/> Mobile <input type="text"/>
Email	<input type="text"/>	<input type="text"/>
Consent to seek information from other insurers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

By providing contact details, you are consenting to New Ireland Assurance phoning or emailing you, if required, for information in connection with this application.

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

## 2. Adding a second person to be covered (life insured)

Is the relationship between the current policy owner and the person to be covered that of husband and wife or joint mortgagees?

☐ Yes ☐ No

If no, please give the reason for the policy:

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Details of person to be added as a person to be covered

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="text"/> Other	
First name		
Surname		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth	DD/MM/YYYY	
Marital status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
	<input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner	
Gross annual earned income	€ <input type="text"/>	
Address		
Telephone	Home	
	Work	
	Mobile	
Email		
Consent to seek information from other insurers	<input type="checkbox"/> Yes <input type="checkbox"/> No	

By providing contact details, you are consenting to New Ireland Assurance phoning or emailing you, if required, for information in connection with this application.

Information means medical and other details given to an insurer by me or any doctor in connection with a life insurance application on my life

**Please proceed to section 3 for changes to Life Choice - You and Family.**

**Please proceed to section 4 for changes to Life Choice - Home.**

**Please proceed to section 5 for changes to Life Choice - Assets.**

### 3. Cover detail: Life Choice – You and Family (Term Assurance)

#### (Single or dual life)

Date change is to take effect  (if not to take effect on next possible date)

#### Benefits

You must maintain **at least one** of Lump Sum on Death, Standalone Specified Illness or Income on Death benefits on your policy.

	First person	Second person
<b>Lump Sum on Death</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/>
<b>Specified Illness</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> <input type="checkbox"/> Accelerated (only available with Lump Sum on Death) <input type="checkbox"/> Additional <input type="checkbox"/> Standalone	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> <input type="checkbox"/> Accelerated (only available with Lump Sum on Death) <input type="checkbox"/> Additional <input type="checkbox"/> Standalone
<b>Term of cover for Lump Sum on Death/Specified Illness</b> (If adding a life, a change to term will apply to both lives).	<input type="checkbox"/> to remain unchanged <input type="checkbox"/> to be extended to <input type="text"/> years from date of change <input type="checkbox"/> to be reduced to <input type="text"/> years from date of change	
<b>Income on Death</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> per month	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> per month
<b>Term of cover for Income on Death</b> (If adding a life, a change to term will apply to both lives).	<input type="checkbox"/> to remain unchanged <input type="checkbox"/> to be extended to <input type="text"/> years from date of change <input type="checkbox"/> to be reduced to <input type="text"/> years from date of change	
<b>Whole of Life Continuation</b> (may only be selected if remaining policy term exceeds 10 years and either Lump Sum on Death or Income on Death are benefits on the policy) (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/>	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/>
<b>Surgery Payment</b> (Only available with Specified Illness)	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Add <input type="checkbox"/> Remove
<b>Accident Payment</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> per week	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> per week
<b>Hospitalisation Payment</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> per day	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> per day
<b>Broken Bones Payment</b>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Add <input type="checkbox"/> Remove

The terms of cover for the five benefits listed directly above will be the longest of the standalone Lump Sum on Death, Specified Illness and Income on Death benefit terms, unless maximum age rules apply.

The above changes will result in a change in the premium for this policy from:

€  per  to €  per

In addition to the premium, a Government levy (currently 1% of the premiums paid) will be collected on each premium due date. If your policy is currently assigned (securing a loan) assignee approval is required before any alterations are made. Benefits are subject to underwriting and policy conditions. It is important to note that certain restrictions, conditions and exclusions apply.

Please proceed to Section 6.

#### 4. Cover detail: Life Choice - Home (Mortgage Protection Assurance)

##### (Single or joint life)

Date change is to take effect	<input type="text" value="DD / MM / YYYY"/>	(if not to take effect on next possible date)
Term of cover	<input type="checkbox"/> to remain unchanged <input type="checkbox"/> to be extended to <input type="text"/> years from date of change <input type="checkbox"/> to be reduced to <input type="text"/> years from date of change	

##### Benefits

Lump Sum on Death	€ <input type="text"/>
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The following benefits (Accelerated Specified Illness, Surgery Payment, Accident Payment, Hospitalisation Payment and Broken Bones Payment) are available only on certain policies. Please refer to your policy conditions to see if these benefits are available on your policy.

Accelerated Specified Illness* (only available with Lump Sum on Death)  (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change  € <input type="text"/>
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	First person	Second person
<b>Surgery Payment*</b> (Only available with Accelerated Specified Illness)	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Add <input type="checkbox"/> Remove
<b>Accident Payment*</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change € <input type="text"/> per week	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change € <input type="text"/> per week
<b>Hospitalisation Payment*</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change € <input type="text"/> per day	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change € <input type="text"/> per day
<b>Broken Bones Payment*</b>	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Add <input type="checkbox"/> Remove

The term of cover for the four benefits listed directly above will be the term of the Lump Sum on Death benefit unless maximum age rules apply.

If adding a life to an existing policy, Lump Sum on Death/Accelerated Specified Illness cover requested above will impact both lives.

The above changes will result in a change in the premium for this policy from:

€ <input type="text"/>	per	<input type="text"/>	to	€ <input type="text"/>	per	<input type="text"/>
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**In addition to the premium, a Government levy (currently 1% of the premiums paid) will be collected on each premium due date. If your policy is currently assigned (securing a loan) assignee approval is required before any alterations are made. Benefits are subject to underwriting and policy conditions. It is important to note that certain restrictions, conditions and exclusions apply.**

**Please proceed to Section 6.**

## 5. Cover detail: Life Choice – Assets (Term Assurance)

### (Single or joint life)

Date change is to take effect	<input type="text" value="DD / MM / YYYY"/>	(if not to take effect on next possible date)
Term of cover	<input type="checkbox"/> to remain unchanged <input type="checkbox"/> to be extended to <input type="text"/> years from date of change <input type="checkbox"/> to be reduced to <input type="text"/> years from date of change	

### Benefits

<b>Lump Sum on Death</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/>
<b>Specified Illness</b> (Required/revised cover)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change <input type="text" value="€"/> <input type="checkbox"/> Accelerated (only available with Lump Sum on Death) <input type="checkbox"/> Additional <input type="checkbox"/> Standalone

If adding a life to an existing policy, cover requested above will impact both lives.

The above changes will result in a change in the premium for this policy from:

€ <input type="text"/>	per <input type="text"/>	to € <input type="text"/>	per <input type="text"/>
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**In addition to the premium, a Government levy (currently 1% of the premiums paid) will be collected on each premium due date. If your policy is currently assigned (securing a loan) assignee approval is required before any alterations are made. Benefits are subject to underwriting and policy conditions. It is important to note that certain restrictions, conditions and exclusions apply.**

**Please proceed to Section 6.**

## 6. Underwriting method

You will need to complete sections 7-10 inclusive if your policy change request includes any of the following:

- addition of a new benefit
- addition of a new life insured
- increase in the amount of cover on an existing benefit (where the Life Events Option does not apply)
- extension to the policy term (where the Medical Free Conversion Option or Life Events Option do not apply)
- amending smoker status to non-smoker

### Life Events Option / Medical Free Conversion Option

**Please refer to your policy conditions which will outline when the Life Events Option/Medical Free Conversion Option applies to your policy.**

- ☐ Life Events Option applies on my policy and I would like to exercise this to increase my benefit cover without underwriting.
- ☐ Life Events Options in relation to Income on Death Benefit applies on my policy and I would like to use this to extend the term on my Income on Death without underwriting.
- ☐ Medical Free Conversion applies on my policy and I would like to use this to extend the term of my Lump Sum on Death and/or Specified Illness without medical underwriting.

**If using the Life Events Option please attach a marriage certificate, birth certificate or confirmation of loan approval as appropriate.**

**If using the Life Events Option or the Medical Free Conversion Option please proceed directly to section 11 - Declarations/Data consent.**

## Teleinterview

We can arrange to get your medical information through a teleinterview by a professional nurse.

To speed up processing your application we strongly recommend that you arrange a teleinterview prior to sending the alteration as it will avoid unnecessary delays in your application. This interview will be recorded. For more information on teleinterviews please go to our website [www.newireland.ie](http://www.newireland.ie)

By providing your phone number(s) below you are consenting to take part in a teleinterview.

Please complete the doctor/clinic details in Section 8 if you are doing a teleinterview.

If you are not doing a teleinterview, you will need to complete the doctor/clinic details in Section 8, the occupation information in Section 9 and the risk assessment in Section 10.

You may contact our teleinterview provider on free phone 1800 805 395 to arrange a suitable time for your teleinterview. You will be given a reference number to record in the field below:

Teleinterview reference number:

	First person		Second person	
Contact numbers for teleinterview	Home		Home	
	Work		Work	
	Mobile		Mobile	
Preferred contact time	<input type="checkbox"/> Morning		<input type="checkbox"/> Morning	
	<input type="checkbox"/> Afternoon		<input type="checkbox"/> Afternoon	
	<input type="checkbox"/> Evening		<input type="checkbox"/> Evening	

If you are not in a position to arrange a teleinterview at this stage we will pass your details to our teleinterview providers who will then contact you to arrange a suitable appointment. Please note that this will likely result in your application taking longer to process.

## 7. Material facts notice and other important information

You are legally obliged to inform us of all relevant information (material facts) in the application process. Material facts are those, which the insurer would regard as likely to influence the assessment and acceptance of a proposal for insurance. If you are in doubt as to whether certain facts are material, such facts should be disclosed.

The policy may be void (there will be no cover under the policy):

- if you do not inform us of all material facts
- if any of the information you provide is not true and complete
- if you do not inform us of any changes in your medical status/state and/or other information before the alteration in cover comes into effect

It is your responsibility to ensure that the information provided is true and complete whether the information was completed by you or on your behalf. All material facts in relation to the person to be covered must be provided by that person and not the policy owner or any other person to be covered.

If you proceed with the alteration, the policy will be based on the information provided:

- as set out on this form containing your application details
- as set out in any other form related to your application
- as set out in any communication from you notifying us of any changes required in advance of the alteration coming into effect
- as set out in any questionnaire completed by you or by a medical examiner and signed by you, and
- by you in any teleinterview you complete.

If you complete a teleinterview it will be recorded and you will be sent a transcript of the teleinterview for you to check and keep for your records. If any information set out in the transcript is inaccurate or incomplete you are required to notify us within 10 working days of receipt of the transcript.

You may submit answers to any medical questions, if you have not already done so, direct to the Chief Medical Officer, New Ireland Assurance, 11-12 Dawson Street, Dublin 2. Please indicate your name and the policy number to which the information applies. All information will be treated in strictest confidence.

We may not necessarily contact your doctor(s). Even if we do, you must still disclose all material facts. We may ask you to have a medical examination with a nurse or a doctor.

Any changes to the information provided in the application process before the proposed alteration in cover comes into effect must be notified immediately in writing to New Ireland.

### Material facts exemption in relation to genetic tests

You are not required to disclose any genetic tests you may have had and we will not have any regards to any genetic tests, which may come into our possession. You are however required to provide us with full details (other than genetic tests) in answer to all the health and lifestyle questions including full medical details about your family history.

## 8. Doctor/clinic details

### First Person to be covered

**Do you have a Doctor in Ireland or abroad?**

☐ Yes ☐ No

Your Doctor details

Name of Doctor:

Address:

Phone number:

### Second Person to be covered

☐ Yes ☐ No

**Have you attended any other Doctor (in Ireland or abroad) in the last 12 months?**

☐ Yes ☐ No

☐ Yes ☐ No

If 'Yes' please provide further information.

### Other Doctor details

Name of Doctor:

Address:

Phone number:

## 9. Occupation information (Do not complete if you are doing a teleinterview)

	First person	Second person
What is your occupation?		
Is your occupation 100% administration/supervisory/managerial?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your work involve any manual duties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes give details including % of working week on manual work	<input type="text"/> %	<input type="text"/> %
Details:		
Does your occupation involve work at sea, underground or use of explosives?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes give details including % of working week spent in any of these situations	<input type="text"/> %	<input type="text"/> %
Details:		
Do you work at heights above 50 feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what % of your time do you spend working above this height?	<input type="text"/> %	<input type="text"/> %

## 10. Risk assessment (Do not complete if you are doing a teleinterview)

Please provide details about any disclosure(s) below such as: exact condition, when diagnosed, tests/investigations results, treatment and any current medication and date of last review with your GP/specialist.

	First person	Second person
<b>1. a.</b> Have you smoked cigarettes, cigars, or pipe tobacco in the last 12 months? <b>b.</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?	<input type="checkbox"/> Yes <input type="checkbox"/> No  Cigarettes <input type="text"/> per day Cigars <input type="text"/> per week Pipe tobacco <input type="text"/> per day	<input type="checkbox"/> Yes <input type="checkbox"/> No  Cigarettes <input type="text"/> per day Cigars <input type="text"/> per week Pipe tobacco <input type="text"/> per day
<b>2.</b> How much alcohol do you drink each week?  <b>Unit guide:</b> Pint beer = 2.0 units Bottle beer = 1.5 units Bottle wine = 7.0 units Measure spirits = 1.0 units Glass wine = 1.0 units.	<input type="text"/> units per week	<input type="text"/> units per week
<b>3. a.</b> What is your height?  <b>b.</b> What is your weight?	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg <input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg <input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg



## 10. Risk assessment (continued)

Please provide details about any disclosure(s) below such as: exact condition, when diagnosed, tests/investigations results, treatment and any current medication and date of last review with your GP/specialist.

	First person		Second person		First person	Second person
	Yes	No	Yes	No	If "Yes", please complete.	If "Yes", please complete.
<b>Medical history details:</b>						
4. Do you currently have or have you ever had any of the following:						
a. heart attack, angina, heart surgery, heart murmur, heart related chest pain 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"/>		
5. Have you ever had or been referred for treatment or counselling for alcohol excess or misuse, or have you ever been advised by a medical practitioner to cease or reduce your alcohol consumption?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. 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"/>		
7. 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"/>		
8. 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 or raised cholesterol?	<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 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 other joint problems?	<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"/>		
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"/>		

## 10. Risk assessment (continued)

	First person		Second person		First person If "Yes", please complete.	Second person If "Yes", please complete.
	Yes	No	Yes	No		
<b>m.</b> abnormal smear test results, hysterectomy, endometriosis, fibroids, ovarian cysts or mammogram which required further investigation? <b>(females only)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>9.</b> Have you had any medical investigations, medical scans, medical tests or surgery within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>10.</b> Are you taking, or have you been advised to take, any prescribed drug(s), medicine(s), tablet(s) or any other treatment(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>11.</b> 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"/>		
<b>Concerning your family:</b>						
<b>12.</b> Have any of your biological parents, brothers or sisters had any of the following medical conditions before age 60:						
<b>(i)</b> 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"/>		
<b>(ii)</b> heart attack, angina, heart by-pass, angioplasty, heart failure, cardiomyopathy, stroke, diabetes, haemochromatosis, high blood pressure or raised cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>(iii)</b> 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"/>		
<b>13.</b> 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"/>		
<b>14.</b> Have you ever had or been advised to have any check up or screening because of your family history? (You do not need to disclose any genetic test you may have had)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

If you answered yes to questions 12 or 13, 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

### 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

	First person		Second person		First person If "Yes", please complete.	Second person If "Yes", please complete.
	Yes	No	Yes	No		
<b>About your travel and interests:</b>						
<b>15.</b> 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"/>		

## 10. Risk assessment (continued)

	First person		Second person		First person	Second person
	Yes	No	Yes	No	If "Yes", please complete.	If "Yes", please complete.
<b>16.</b> In the next 12 months, do you intend to travel or reside for more than 30 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"/>		
<b>17.</b> 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? If yes, please complete the appropriate hobby questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Total market cover:</b> <b>18.</b> 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? 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"/>		

## 11. Declarations / Data protection consent

### I declare that:

- I have read and understand the notes in relation to material facts and understand that if I fail to disclose all material facts in this policy change request form, in any questionnaire signed by me, and in any teleinterview I complete, the contract with New Ireland Assurance could be void, New Ireland Assurance may retain all premiums paid and no benefits may be provided by the policy
- I have read and understand the replies to all questions in this policy change request form and confirm that all statements herein and any statements written at my request or in any questionnaire completed by me or by a medical examiner in connection with this application signed by me are true and complete and shall form the basis of the proposed contract.

### I consent to you seeking:

- any information from any doctor now or in the event of a claim who has at any time attended me and I authorise them to give New Ireland Assurance such information. I agree that this authority will remain in place after my death
- any information from any life insurer to which a proposal has been made on my life and I authorise the giving of such information to New Ireland Assurance (if I have answered yes to the "Consent to seek information from other insurers" question).

### I agree that:

- if I have provided a telephone number, New Ireland Assurance or a duly authorised agent of New Ireland Assurance may contact me in person, by phone, if it considers it necessary to obtain further medical or other information relating to this policy change request.

### I understand that:

- the proposed policy changes will not come into force until New Ireland Assurance has accepted me and I have made the first revised premium payment
- my policy will never have a cash value
- New Ireland Assurance reserves the right to test declared non-smokers for nicotine
- any changes to the statements in
  - this policy change request form
  - any other questionnaire signed by me relating to this change request
  - any teleinterview completed by me, and
  - any statement made by me in writing must be notified in writing to New Ireland Assurance before the change(s) come into force.
- any incomplete or inaccurate information set out in the transcript of any teleinterview completed by me must be notified to New Ireland Assurance within 10 working days of receipt of the transcript.
- in the event of my policy change request not proceeding, information provided in connection with this policy change request will be retained by New Ireland Assurance for a period of six years to facilitate any future application by me and as a protection against non-disclosure of material facts.

## 11. Declarations / Data protection consent

### I confirm that:

- where I have selected to add one or more Accelerated Specified Illness Benefit, Standalone Specified Illness Benefit, Surgery Payment, Accident Payment, Hospitalisation Payment, and/or Broken Bones Payment, the restrictions, conditions and exclusions that attach to the benefit(s) have been fully and clearly explained to me.

### Data Protection

The "Data Controller" for the purposes of the Data Protection Acts 1988-2003 is New Ireland Assurance Company plc (New Ireland). The personal data being collected on this form is for the purposes of processing your application and may be disclosed in accordance with and to other parties as identified and consented to in the paragraphs below.

"EEA" means the European Economic Area and consists of the 28 EU Member States as well as Norway, Iceland and Liechtenstein.

"Information" means any information including medical and non-medical given by me or on my behalf in connection with this application or any further information which may be given at a later stage either in writing, by email, at a meeting or over the telephone.

"Marketing" means direct marketing and cross-selling of the services and/or products provided by New Ireland or arranged by New Ireland with a third party.

I understand and consent that New Ireland and its duly authorised agents may:

- contact me by phone or by letter in relation to the administration (including any contractual review) of the contract;
- hold and use the Information on computer file, in any other dematerialised form or in written hard copy on its own behalf and may use or pass the Information to third parties for administration, regulatory, customer care and service purposes;
- disclose and/or transfer my Information to other countries, including countries outside of the EEA, for any of the purposes specified, to persons who have been approved by New Ireland and in a manner compliant with applicable data protection legislation;
- use my Information to carry out statistical analysis and market research.

I agree that New Ireland or a duly authorised agent of New Ireland may contact me in person, by phone, letter, e-mail or other electronic means if it considers that my financial planning arrangements need to be reviewed, my level of cover needs to be revised, and/or to provide me with general information relating to the contract by e-mail or other electronic means with New Ireland at any time.

☐ Yes ☐ No

I agree that the Information may be held and used by New Ireland for Marketing purposes, including Marketing by e-mail or other electronic means.

☐ Yes ☐ No

I understand that I may write to advise New Ireland to cease to hold and use the Information for Marketing purposes at any time.

Sign  
Here

First person covered:

Date:

D	D	M	M	Y	Y	Y	Y

Sign  
Here

Second person  
covered / second  
person to be covered  
(where applicable):

Date:

D	D	M	M	Y	Y	Y	Y

Sign  
Here

First policy owner:

Date:

D	D	M	M	Y	Y	Y	Y

Sign  
Here

Second policy owner  
(where applicable):

Date:

D	D	M	M	Y	Y	Y	Y



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