



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### SECTION 1 - INTRODUCTION

	1st Applicant	2nd Applicant
Client Name(s)		
Form of Meeting (Face to Face/Telephone/Email/Zoom)		
Client Support - Vulnerable Characteristics? (if Yes, complete details in Section 16)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Was the client(s) accompanied in meeting? (if so, who with?)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Client Objectives & Priorities? State here in the clients own words the main purpose of the meeting: "FOCUSED" – focus on just one or two type(s) of cover, such as Mortgage Protection, Family Protection or IHT Planning, etc. Or "HOLISTIC" - Full Protection Review, Interim Review, Life/Circumstances Change, etc.	Focused <input type="checkbox"/> Holistic <input type="checkbox"/> Main Purpose of Meeting	Focused <input type="checkbox"/> Holistic <input type="checkbox"/> Main Purpose of Meeting

### SECTION 2 - PERSONAL DETAILS

	1st Applicant	2nd Applicant
Title		
Forename(s)		
Surname		
Date of Birth		
Age		
Gender		
Marital Status		
Nationality		
Country of Residence		
Retirement Age		
Daytime Telephone Number		
Email Address		
Dependants? (Name, Age or DoB, Relationship)		



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### SECTION 3 - ADDRESS DETAILS

	1st Applicant	2nd Applicant
Current Address (inc postcode)		
Residential Status (Owner Occupier / Renting / With Parents)		
Previous Residential Address (if lived at present address for less than 3 years)		

### SECTION 4 - OCCUPATION & INCOME DETAILS

	1st Applicant	2nd Applicant
Main Occupation Status (Employed or Self-Employed)		
Job Title		
Form of Employment (Full Time / Part Time / Contractor / Temp / Unemployed / Education / Home Person)		
Name of Employer or Business		
Basic Annual Salary (Gross)		
Overtime/Bonuses/Commission/Allowances		
<b>Net Monthly Income (A)</b>		
Dividends, latest annual		
Net Profits, latest annual (@ %age of shareholding)		
<b>Net Monthly Income Equivalent (Divi's or NP's/12) (B)</b>		
<b>OTHER MONTHLY INCOME</b>		
2nd Job/Employment Income (per month)		
Pension Income (Occupational or Personal Pension)		
State Pension (monthly equivalent)		
Investment Income		
Rental Income (net)		
Maintenance/Alimony		
State Benefits (Amount, Type)		
Miscellaneous Income		
<b>Net Monthly Other Income (C)</b>		
<b>TOTAL NET MONTHLY INCOME (A+B+C)</b>		



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## PROTECTION QUESTIONNAIRE

### SECTION 5 - EXISTING EMPLOYEE BENEFITS OR BUSINESS PROTECTION

	1st Applicant	2nd Applicant
<b>EMPLOYEE BENEFITS</b>		
Sick Pay - SP (Amount: % of Salary or in £, Duration, Term)		
Income Protection - IP or PHI (Amount: % of Salary or in £, Duration, Term)		
Death In Service – DIS (Amount: in £ or Multiple of Salary, Duration, Term)		
Group Private Medical Insurance – PMI		
<b>BUSINESS PROTECTION (if applicable)</b>		
Relevant Life Cover (Amount: in £, Term, Premium)		
Key Person Cover (Amount: in £, Term, Premium)		
Shareholder Protection Insurance (Amount: in £, Term, Premium)		
Business Loan Protection (Amount: in £, Term, Premium)		

### SECTION 6 - LIABILITIES – MORTGAGE & CREDIT COMMITMENTS

Main Residence Mortgages, Buy to Lets, Credit Cards, Personal Loans, HP, Car Finance, Secured Loans, Further Advances, Bank Overdraft, etc...

Client 1, 2 or joint	Type of Finance	Finance Provider	Balance o/s	Months o/s	Monthly Payment	Secured
			£		£	Y <input type="checkbox"/> N <input type="checkbox"/>
			£		£	Y <input type="checkbox"/> N <input type="checkbox"/>
			£		£	Y <input type="checkbox"/> N <input type="checkbox"/>
			£		£	Y <input type="checkbox"/> N <input type="checkbox"/>
			£		£	Y <input type="checkbox"/> N <input type="checkbox"/>
			£		£	Y <input type="checkbox"/> N <input type="checkbox"/>



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### SECTION 7 - EXISTING PROTECTION POLICIES

	Policy 1	Policy 2	Policy 3	Policy 4
Life / Lives Assured				
Type of Policy				
Purpose of Policy (family, mortgage, business, etc.)				
Insurance Company				
Amount of Cover	£	£	£	£
Monthly Premium	£	£	£	£
Are Premiums Guaranteed or Reviewable				
Start Date				
Original Term				
Remaining Term or End Date				
Deferred Period (IP only)				
Written in Trust (if yes, please state beneficiaries)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Any health issues since you incepted this policy(ies) (if yes, please state)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>



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## PROTECTION QUESTIONNAIRE

### SECTION 8 - MONTHLY EXPENDITURE – BUDGET PLANNER

**Note:** Please include the equivalent monthly figure if you pay weekly, quarterly or annually. Use the content of bank statements for accuracy.

	1st Applicant	2nd Applicant
Total of Continuing Credit Commitments inc, mortgage (total from SECTION 6 above)	£	£
Rent / Board	£	£
Council Tax	£	£
Gas / Oil	£	£
Electric	£	£
Water	£	£
Mobile Phone	£	£
TV / Broadband	£	£
Property Maintenance (Service Charge, Ground Rent, etc.)	£	£
Building & Contents Insurance	£	£
Food Shopping & Household Goods (Monthly Average Spend)	£	£
Maintenance Payments / Alimony / CSA Payments	£	£
Travel (eg. train, bus, tube)	£	£
Car Costs - Fuel, Tax, MoT, Servicing, Repairs (Monthly Average Spend)	£	£
Subscriptions (e.g. gym, golf, tennis, films, magazines, etc.)	£	£
Pets (food, insurance, grooming , etc.)	£	£
Pension Contributions (non-automatic salary deductions)	£	£
Insurances – Other (e.g. life cover, car insurance, medical, dental, phone, etc.)	£	£
Private School / Education Fees	£	£
Childcare costs	£	£
Regular Savings (e.g. ISA's, savings policies, endowments, etc.)	£	£
Social / Lifestyle Costs (meals out, theatre, cinema, etc.)	£	£
<b>TOTAL NET MONTHLY EXPENDITURE</b>	£	£



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## PROTECTION QUESTIONNAIRE

### SECTION 9 - DISPOSABLE INCOME – AFFORDABILITY, BUDGET & EMERGENCY FUND

	1st Applicant	2nd Applicant	or Joint
<b>TOTAL NET MONTHLY INCOME</b> (from SECTION 4)			
<b>TOTAL NET MONTHLY EXPENDITURE</b> (from SECTION 8)			
<b>TOTAL NET DISPOSABLE INCOME</b> (Net Income minus Net Expenditure)			
How much can you afford each month for your protection needs? (your expected budget)			
How much capital do you need to provide for potential emergencies? (e.g. 6 or 12 months total expenditure, 1 years net income, 6 months salary, etc..)			

### SECTION 10 - ASSETS

	1st Applicant	2nd Applicant	or Joint
Net Equity in Current Main Residence			
Net Equity in 2nd Home			
NetTotal Equity in Investment (BTL) Property			
Deposit / Savings Account			
Investments			
Pension Funds			
Other Assets			
<b>TOTAL</b>			



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### SECTION 11 - VITALS, HEALTH & LIFESTYLE DETAILS

	1st Applicant	2nd Applicant
Height (ft/in or cm)		
Weight (st/pds or kg)		
Waist Size (male) or Dress Size (female)		
Have you recently lost or gained weight?		
How many times a week do you exercise for at least 30 minutes		
Have you used any tobacco or nicotine products in the last year, including electronic cigarettes or vapes?		
If so, number of cigarettes/cigars per day?		
How many units of alcohol do you drink per week? <small>(One unit = a single measure of spirits, 1 glass of wine, or 1/2 pint of beer)</small>		
Have you ever been advised by a professional to reduce your alcohol intake? <small> Lorem ipsum dolor sit amet,</small>		
Have you ever taken any non-prescribed or recreational drugs? <small>(e.g. steroids, meth, marijuana, cannabis, heroin, ecstasy, cocaine, opioids, amphetamines – ignore CBD oil)</small>		
Do you ride motorbike? <small>(if so, regular or occasional use; licensed &amp; insured?)</small>		
Doctor/GP Name and Address		

### Soft Facts



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### SECTION 12 - MEDICAL FILTERS

THE NEXT QUESTIONS DETERMINE IF YOU NEED TO COMPLETE AN ADDITIONAL APPENDIX AT THE END OF THIS FORM. IF YOU ANSWER **"YES"** TO ANY OF THE FOLLOWING QUESTIONS, THEN PLEASE COMPLETE THE RELEVANT APPENDIX...

	1st Applicant	2nd Applicant	APPENDIX
<p><b>Recent Health</b></p> <p>In the last 5 years have you seen a doctor or medical professional or been to hospital? (excluding minor occasional visits, such as colds, oral contraceptive, smear tests, etc.)</p>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	A
<p><b>Medical History</b></p> <p>Have you <b>ever</b> suffered from a serious, critical or chronic condition or diagnosis? (including mental health conditions)</p>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	B
<p><b>Family History</b></p> <p>Has any of your natural parents, brothers or sisters suffered from a serious medical condition or died before the age of 60?</p>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	C
<p><b>Travel or non-UK Residency</b></p> <p>Have you <b>ever</b> lived abroad or intend to do so in the future? (less than 30 days duration is excluded)</p>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	D
<p><b>Manual Work or Hazardous Occupations</b></p> <p>Does your job involve Manual Work or working in Hazardous Conditions? (including working at heights, underground, underwater, offshore, explosives, firearms, armed forces, aviation or sports)</p>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	E
<p><b>Hazardous Sports or Pursuits</b></p> <p>Do you partake in any dangerous hobbies, sports or pastimes? (skiing, snowboarding, mountaineering, flying, diving, motor sports, water sports)</p>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	F

### SECTION 13 - WILLS & LPA

	1st Applicant	2nd Applicant
Do you have a Will?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
When it was last reviewed?		
Have you arranged your LPA? (Lasting Power of Attorney)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Is your LPA in force? (Actioned or Triggered)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>





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## PROTECTION QUESTIONNAIRE

### SECTION 14 - BANK DETAILS - DIRECT DEBIT

	1st Applicant	2nd Applicant	or Joint
Account Name			
Bank Name			
Account Number			
Sort Code			
Preferred Premium Collection Date			

### SECTION 15 - SOFT FACTS & ADDITIONAL INFORMATION

A large, empty grey rectangular area intended for providing soft facts and additional information.



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### SECTION 16 - VULNERABLE CONSUMERS

Please tick all those that apply, or tick "NONE" if there are no characteristics present...

#### VULNERABLE CONSUMER CHARACTERISTICS

**tick** **No Characteristics Present**

NONE

**tick** **Health**

Physical disability

Severe or long-term illness

Hearing or visual impairment

Mental health condition or disability

Addiction

Low mental capacity or cognitive disability

Suicidal (previously)

**tick** **Capability**

Low knowledge/confidence managing finances

Limited literacy or numeracy skills

Limited English language skills

Limited digital skills

Learning difficulties

No or low access to help or support

**tick** **Life Events**

Retirement

Aged 75+

Bereavement

Income Shock

Relationship Breakdown

Domestic abuse (inc economic control)

Caring responsibilities

Unemployment

Being a new parent

**tick** **Resilience**

Inadequate or erratic income

Over-indebtedness

Low savings

Low ability to withstand emotional shocks

### SECTION 17 - DECLARATION

I/we confirm that the information detailed in this form is accurate and correct. I/we understand that advice and recommendations will be made based on this information.

I/we understand that if information I/we provide is incorrect or incomplete, my/our adviser will be unable to take into account all of my/our personal circumstances when giving advice or making recommendations. This will restrict the ability of my/our adviser to provide the most appropriate advice or recommendation.

Where I/we have knowingly made false or misleading representations to my adviser or provided information which is subsequently found to be false, this may mean that my transaction will not proceed and/or that my adviser may be required to disclose that I have made such false representations. Such disclosure may be made to any provider who may consider my application or any regulatory or supervising authority.

I am/we are aware that provision of information to the adviser places me/us under no obligation to conclude any transaction.

I/we confirm receipt of the Terms of Business/Privacy Notice and agree with the terms therein.

I/we give my/our consent for this information to be used for the purpose of recommending and/or arranging protection insurance product(s) on my/our behalf.

#### Applicant 1

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

#### Applicant 2

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### NEEDS ANALYSIS

**\*\*\* ADVISER ONLY TO COMPLETE \*\*\***

**ADVISER GUIDANCE:**

In this section you need to identify and confirm all the products that are suitable to cover any shortfalls (the “Needs”). For **FOCUSED** meetings this should include **just** the products that meet the intended objectives and priorities of the client. For **HOLISTIC** meetings, this needs to include **all** cover and types of policies that are available to client and meets all their shortfalls regardless of objectives. The needs identified must be confirmed **without** taking into account affordability and budget. Following the completion of this Fact Find and your resulting research, you can then tailor your recommendations to match the clients priorities and budget.

### THE FOLLOWING CONFIRMS THE COVER YOU HAVE IDENTIFIED....

	1st Applicant	2nd Applicant	or Joint
<b>MORTGAGE PROTECTION (DTA or LTA)</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Amount (£)			
Why this amount? <small>(repay existing mortgage, cover for BTL mortgages, etc.)</small>			
Decreasing Term or Level?			
Term (Yrs)			
Why this term? <small>(to end of mortgage term, etc.)</small>			
Type? <small>(single life, joint life, individual cover/policies)</small>			
<b>LIFE COVER (LTA, DTA or FIB)</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Amount (£):			
Why this amount?: <small>(multiple of salary such as 4 or 8 x salary, repay existin debts, etc.)</small>			
Purpose(s): <small>(family, legacy, etc.)</small>			
Term (Yrs):			
Why this term?: <small>(to retirement age, until children are non-dependant, etc.)</small>			
Type?: <small>(single life, joint life, individual cover/policies)</small>			
Lump Sum or Monthly Income (FIB)?:			
Intended Beneficiaries: <small>(spouse, partner, children, etc.)</small>			



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## PROTECTION QUESTIONNAIRE

### NEEDS ANALYSIS

	1st Applicant	2nd Applicant	or Joint
<b>CRITICAL ILLNESS COVER (CIC)</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Amount (£)			
Why this amount? <small>(repay mortgage, emergency fund, cover for BTL mortgages, etc.)</small>			
Term (Yrs)			
Why this term? <small>(to retirement age, end of mortgage term, etc.)</small>			
Type? <small>(single life, joint life, individual cover/policies)</small>			
<b>INCOME PROTECTION (IP)</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Monthly Income Amount (£)			
Why this amount? <small>(maximum of 65% of salary or sufficient to cover all expenditure)</small>			
Term (Yrs/to Age) <small>(always to retirement age)</small>			
Deferred Period? <small>(usually to correspond with when sick pay stops, or 4 weeks if self-employed)</small>			
Benefit Payment Period? <small>(always to retirement age)</small>			
<b>WHOLE OF LIFE (WOL)</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Amount (£)			
Why this amount? <small>(sufficient to cover the purpose/s below)</small>			
Purpose? <small>(funeral expenses, inheritance tax mitigation, legacy to family, etc.)</small>			
Type? <small>(single life, individual cover/policies, joint life first death or second death)</small>			
Intended Beneficiaries <small>(spouse, partner, children, etc.)</small>			
<b>PRIVATE MEDICAL INSURANCE – PMI</b>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Cover Options? <small>(all options, or out-patient cover, mental health, therapies, optical, dental, hearing, travel cover)</small>			
Where? <small>(consultant select, hospital list, etc.)</small>			
Excess? <small>(no excess, or £100, £250, £500, £1000)</small>			
Underwriting? <small>(full medical underwriting, moratorium, or continued medical exclusions if switching insurer)</small>			



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## PROTECTION QUESTIONNAIRE

### NEEDS ANALYSIS

	1st Applicant	2nd Applicant	or Joint
<b>BUSINESS COVER</b>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
State type, purpose, reasons, level of cover, term, beneficiaries, etc..			
<b>OTHER COVER TYPE(S)</b> (e.g. Gift Inter Vivos, etc.)	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
State purpose, reasons, level of cover, term, beneficiaries, etc..			

### ADVISER TO TICK ALL THOSE THAT APPLY...

### RECOMMENDATIONS

	Mortgage Cover	Life Cover	Income Protection	Whole of Life
Do existing policy(ies) cover the Needs identified?	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Is there a shortfall in cover?	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Is it likely to be cheaper to top up existing cover rather than cancel and replace?	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Is it recommended existing cover is cancelled and replaced? (if so, complete a Replacement / Cancellation Proforma)	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Are there any shortfalls that cannot be covered? (if so, state reasons)	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>

### Notes



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### APPENDIX A - RECENT HEALTH

In the last 5 years, regardless of whether you have seen a doctor, required treatment or had time off, have you...

	1st Applicant	2nd Applicant
Been off work for more than 2 weeks?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Received any treatment that lasted more than 4 weeks?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you currently awaiting the results of any medical consultation, check-up, investigation, scans or tests?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Been prescribed any drugs or been given any other treatment in the last 12 months?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Asthma, bronchitis or any other respiratory disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
A new unexplained continuous cough, fever or high temperature?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Tested positive or diagnosed with COVID-19, advised to self-isolate or been in contact with someone diagnosed or suspected of having Coronavirus?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Numbness, loss of feeling or tingling of the limbs or face, loss of balance or co-ordination?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Seizures, fits, fainting or blackouts?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any disorder of the eyes or ears, including blurred or double vision, or impaired hearing? (you can ignore sight problems corrected by glasses or contact lenses)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Arthritis, back pain, sciatica, neck, knee or wrist pain or any other joint, bone or muscle disorder (including RSI)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any disorder of the digestive system, liver, stomach, pancreas or bowel?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any blood disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any thyroid disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any disorder of the kidney, bladder or genitor urinary system? (including urinary tract infections and blood or protein in the urine)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Tested positive for HIV, Hepatitis B or C or awaiting results?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Treatment or a positive test for any sexually transmitted disease ?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Depression, anxiety, stress, fatigue or nervous breakdown?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Been admitted overnight to hospital or referred to a psychiatrist for mental illness, anorexia or bulimia?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Undergone any surgical procedures or been a recipient of blood products outside the European Union?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

If you answered “Yes” to any of the questions in this section please complete the additional Information below

	Condition 1	Condition 2
Applies to Applicant 1 or 2?		
Name of condition?		
Date first occurred?		
Date last occurred?		
Symptoms?		
How often do symptoms occur?		
Do you take any medication? If so please give details		
How many days have you had off relating to the above condition?		
When was your most recent time off work relating to above condition?		
Are you receiving treatment for this condition or taking any medication? (if so please provide details)		
Will you have to have any operation/treatment in the future related to this condition? (if so please specify the dates this is to occur?)		



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## PROTECTION QUESTIONNAIRE

### APPENDIX B - MEDICAL HISTORY

Note: if you answer “Yes” to any of the following questions then please provide further information in the box below

Have you <u>EVER</u> had any of the following;	1st Applicant		2nd Applicant	
Problems with blurred vision, dizziness, balance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Chest pain, heart attack/failure, heart condition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Stroke, mini stroke, Huntington’s Disease, brain haemorrhage or aneurysm?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes, sugar in the urine?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Condition of nervous system (i.e. the brain, spinal cord and nerves), multiple sclerosis, optic neuritis, cerebral palsy, paralysis, Parkinson's disease?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Alzheimer’s disease or dementia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Loss of feeling, balance or persistent pain bad enough to seek medical help?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cancer, lymphoma, leukaemia, melanoma, cyst, tumour or lump?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Positive HIV test, Hepatitis B or C or awaiting results?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Peripheral vascular or any disease or disorder of the aorta or arteries?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mental Health conditions?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

#### Further Information



**CITY FINANCE BROKERS**  
**PROTECTION QUESTIONNAIRE**

**APPENDIX C - FAMILY HISTORY**

Have either of your natural parents, brothers or sisters suffered or died before the age of 60 from any of the following?

	1st Applicant		2nd Applicant	
Heart disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Stroke	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Raised cholesterol	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Breast cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Ovarian cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Colorectal cancer (e.g. cancer of the colon or rectum)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cancer (other)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Multiple Sclerosis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Huntington's Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Polycystic Kidney disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Polyposis of the colon	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Any other hereditary disorder	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**If you have answered "Yes" to any of the above questions please give details below**

Applies to Applicant 1 or 2?			
Type of Disease			
Family Member			
Age diagnosed			
Is your mother still alive? If so, current age?			
Is your father still alive? If so, current age?			

**Further Information**





# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### APPENDIX D - TRAVEL

	1st Applicant		2nd Applicant	
During the last 2 years have you spent more than 90 consecutive days in Africa, the Caribbean, Russia, Thailand or Ukraine?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
During the next 2 years do you intend to spend more than 30 consecutive days outside of the UK?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you lived or worked outside of the UK for more than 3 months in the last 5 years, or do you intend to do so?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

### Further Information



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### APPENDIX E - MANUAL WORK AND HAZARDOUS OCCUPATIONS

	1st Applicant		2nd Applicant	
Does your occupation involve any manual work? (such as carrying or lifting, moving goods, working with tools or machinery, crawling or kneeling)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Working at heights over 10 feet (3 meters)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If so, what is the highest & average height you work at and how often?				
Working underground?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Working underwater?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Working offshore (e.g. oil, gas industry)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Working with explosives or firearms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Armed Forces?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Professional Sports?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Aviation (excluding as a fare paying passenger)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**If you answered "Yes" to the above then please give further details below**

	1st Applicant	2nd Applicant
Vocation/Occupation?		
Is this your main, primary job or a 2nd job?		
What percentage of time would you spend doing manual work?	%	%
What manual work do you carry out?		
What percentage of time would you say you spend driving?	%	%
Business miles travelled per year?	<b>Miles</b>	<b>Miles</b>
Hours worked per week?	<b>Hours</b>	<b>Hours</b>
Are you currently absent from work?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

### Further Information



# CITY FINANCE BROKERS

## PROTECTION QUESTIONNAIRE

### APPENDIX F - HAZARDOUS PURSUITS & SPORTS (excluding one-off occasions)

	1st Applicant		2nd Applicant	
Scuba or Deep Sea Diving?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sky Diving?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Flying?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Motor Sports?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mountaineering or Rock Climbing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Skiing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Water Skiing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Water Sports?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

#### Further Information