Client Protection Fact Find

Mortgage Services 4u Ltd are directly authorised and regulated by the Financial Conduct Authority - FCA Number 490202.

Registered under the Data Protection Act - Licence No. Z1513056

Consultant	
IDD letter issued	
Date of 1st client contact	

The information requested in these pages is entirely confidential. Periodically Mortgage Services 4u may have to confirm that the information is current.

The personal and financial information provided in this document will be used in assisting Mortgage Services 4u in offering you the best advice as required by the Financial Services and Markets Act 2000. The personal data provided will be stored and used in accordance with the Data Protection Act 1998.

I/we have received the Mortgage Services 4u Initial Disclosure Document and Business Card.

PERSONAL DETAILS		
	Self	Partner
Title :		
Forename :		
Middle Name :		
Surname :		
Date Of Birth :		
Daytime telephone :		
Evening telephone :		
Mobile telephone :		
Home Address : **Postcode :**		
E-mail address :		
Marital Status :		
Smoker : **(If Yes, age started)**		
Employment Status :		
Full / Part Time :		
Occupation :		

Does Job Involve Working At Heights (If Yes please state highest height) :		
Does Job Involve Hazardous Duties (if yes please enter brief description) :		
Are you a member of the TA or Armed Forces :		
What Percentage do you spend each week on these activities :	**Admin / Office Work %** **Manual Work %** **Driving %** **Total 100 %**	**Admin / Office Work %** **Manual Work %** **Driving %** **Total 100 %**
If you Drive please state Annual Mileage :	**Miles**	
Annual Earned Income :	£	£
How many hours worked a week :		

RESIDENCY & TRAVEL		
	Self	Partner
In the next 6 months will you be moving from the country :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Have you lived outside the UK for more than 6 months within the last 2 years :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐

EXTRA PERSONAL INFORMATION		
	Self	Partner
Likely Retirement Age :		
Have you made a will :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐

DEPENDANTS		
Name	**Relationship**	**Date Of Birth**

ESTABLISHING YOUR LIFESTYLE AND HEALTH		
What is your height :	Feet Inches	Feet Inches
What is your weight :	Stones Pounds	Stones Pounds
What is your waist/dress size :		
In the last 3 months has your weight increased or decreased by 7 Lbs other than (Stopping Smoking, Pregnancy or Dieting) :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
How many units of alcohol do you drink in an average week :	**Units**	**Units**
Have you smoked in the last 12 months :	**YES** ☐ **NO** ☐ **If yes:-** **Cigarettes a day** ☐ **Cigars a day** ☐ **Pipes a day** ☐	**YES** ☐ **NO** ☐ **If yes:-** **Cigarettes a day** ☐ **Cigars a day** ☐ **Pipes a day** ☐
Do you take part in any hazardous leisure activity :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Have you ever been advised to reduce your smoking or alcohol intake:	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Have any of your parents, brothers or sisters ever had any of the following medical conditions before they reached age 60? -Alzheimer's disease -Cancer -Diabetes -Haemochromatosis -Heart Disease/Attack -Angina -Huntington's Disease -Motor Neurone Disease -Multiple Sclerosis -Muscular Dystrophy -Parkinson's Disease -Polycystic Kidney Disease -Stroke -Other hereditary disorder	**YES** ☐ **NO** ☐ **Relation:** **Age when Diagnosed:** **Condition:**	**YES** ☐ **NO** ☐ **Relation:** **Age when Diagnosed:** **Condition:**

Have you ever used recreational Drugs :	YES ☐ NO ☐	YES ☐ NO ☐
Have you ever tested positive for AIDS, HIV, Hepatitis B or C :	YES ☐ NO ☐	YES ☐ NO ☐
In the last 5 years have you had any exposure to the risk of HIV infection :	YES ☐ NO ☐	YES ☐ NO ☐
Have you ever tested positive for any STD's :	YES ☐ NO ☐	YES ☐ NO ☐

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING		
Multiple Sclerosis, Parkinsons Disease, Paralysis, Epilepsy, Alzheimers Disease, Dementia or cerebral palsy :	YES ☐ NO ☐	YES ☐ NO ☐
Any Neurological complaint, dizziness, involuntary shaking, loss of feeling or tingling of limbs or face :	YES ☐ NO ☐	YES ☐ NO ☐
Cancer, Tumour, Leukaemia, Hodgkins decease, lymphoma, melanoma or any malignant condition :	YES ☐ NO ☐	YES ☐ NO ☐
Irregular heatbeat, heart murmur or heart disease including angina, heart attack or chest pains :	YES ☐ NO ☐	YES ☐ NO ☐
Stroke, Transient Ischaemic Attack, Brain Haemorrhage or brain injury :	YES ☐ NO ☐	YES ☐ NO ☐
Diabetes or sugar in the urine :	YES ☐ NO ☐	YES ☐ NO ☐
Any Nervous or mental disorders :	YES ☐ NO ☐	YES ☐ NO ☐
Any Hereditary Disorder:	YES ☐ NO ☐	YES ☐ NO ☐
Any disorder of the eyes or blurred/double vision, not corrected by glasses or contact lenses :	YES ☐ NO ☐	YES ☐ NO ☐

IN THE LAST 5 YEARS HAVE YOU HAD ANY OF THE FOLLOWING		
Cysts, Growths, lumps, or any mole or freckle that has bled, become painful, changed colour or increased in size :	YES ☐ NO ☐	YES ☐ NO ☐
Bronchitis, pneumonia or other lung disorder :	YES ☐ NO ☐	YES ☐ NO ☐
Any disorder of the digestive system, gall bladder, stomach, bowel or liver :	YES ☐ NO ☐	YES ☐ NO ☐
A Thyroid Disorder :	YES ☐ NO ☐	YES ☐ NO ☐
Any disorder of the kidneys or bladder :	YES ☐ NO ☐	YES ☐ NO ☐
Fits or blackouts :	YES ☐ NO ☐	YES ☐ NO ☐
Any disorder of the Muscles, bones, joints or limbs :	YES ☐ NO ☐	YES ☐ NO ☐
A slipped disc or other back or neck disorder :	YES ☐ NO ☐	YES ☐ NO ☐
Are you certified unfit for work :	YES ☐ NO ☐	YES ☐ NO ☐
Prostate enlargement or abnormal PSA :		MALE ONLY QUESTION
Any abnormal cervical smear, mammogram or biopsy of the breast :	FEMALE ONLY QUESTION	
Any disorder of the skin or ears :	YES ☐ NO ☐	YES ☐ NO ☐

ASTHMA		
In the last 2 years have you had asthma : **If yes, please enter prescription and date of last attack :**	YES ☐ NO ☐	YES ☐ NO ☐

BLOOD PRESSURE		
In the last 5 years have you had any treatment for raised blood pressure or been advised to have your blood pressure monitored: If yes, please enter prescription and date of last reading if known :	YES ☐ NO ☐	YES ☐ NO ☐

CHOLESTEROL		
In the last 5 years have you had any treat for raised cholesterol levels : If yes, please enter prescription and date of last reading if known :	YES ☐ NO ☐	YES ☐ NO ☐

ADDITIONAL INFORMATION		
If you have answered YES to any of the preceeding questions, please provide extra information such as dates, medication etc with regards to the medical information :		

DOCTORS DETAILS		
Name Of Doctor :		
Name Of Surgery Including Address and Postcode :		
Telephone Number :		

COVER REQUIRED		
Type of Cover Required :	Level Term Assurance ☐ Decreasing Term Assurance ☐ Critical Illness ☐ Family Income Protection ☐ Personal Health Insurance ☐	Level Term Assurance ☐ Decreasing Term Assurance ☐ Critical Illness ☐ Family Income Protection ☐ Personal Health Insurance ☐
Amount of Cover Required		
Term Required :		
Waiver of Premium :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Would the policy need to be put into trust :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Affordability Budget :	£	£
Is this life cover in relation to existing financial commitments :	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐

BANK DETAILS		
Name Of Account :		
Name of Bank & Address :		
Sort Code :		
Account Number :		
Preferred collection date :		

This information has been provided in strictest confidence and it places me/us under no obligation. Advice and recommendations will be made based on the information detailed on this form. I/we understand that where I/we have declined to provide information, the advice or recommendations put forward by Mortgage Services 4u will be correspondingly restricted and will not take into account all of my/our personal circumstances.

Please note, that it is your duty when submitting an application to obtain protection, to answer all questions in respect of personal and family medical history and previous claims history, including those rejected or withdrawn fully and honestly, as this may affect an insurers acceptance terms and lead to future claims being refused.