



INTERNATIONAL TERM ASSURANCE
APPLICATION FORM

HOW TO FILL IN THIS APPLICATION FORM

Please could you send your birth certificate with this Application. For married women or widows, please could you also send your marriage certificate.

Please read all of this form and contact your Financial Adviser if there are any questions that are unclear.

Please use BLOCK CAPITALS and black ink throughout and tick the boxes where appropriate.

If you make a mistake please cross it out, put in the correct word or words and initial next to the correction.

Help us to assess your Application fairly by telling us all the information that may affect our decision to insure you. **If you are uncertain about whether any particular fact would influence our decision, you should include it. You may find that if you do not, a claim in the future could be invalid.**

If anything about your health or circumstances changes after you have completed this Application and before we assume risk for the Cover applied for you must let us know immediately.

Even if you have previously completed an application to Friends Provident International, we still need you to fill in this one with all the questions answered in full.

If you would prefer, you may complete the medical questions in private and return the Application Form direct to the Chief Medical Officer.

PART A – TO BE COMPLETED BY THE APPLICANT(S)

SECTION 1 – LIFE (LIVES) ASSURED

Definition: The Life (Lives) Assured is (are) the person(s) on whose Life (Lives) the plan is to be written. The Life (Lives) Assured is (are) normally the same as the Applicant(s).

	Life Assured 1			Life Assured 2 (if applicable)		
1 Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>
	Other Please Specify <input type="text"/>			Other Please Specify <input type="text"/>		
2 Surname	<input type="text"/>			<input type="text"/>		
3 First name(s)	<input type="text"/>			<input type="text"/>		
4 Current address	<input type="text"/>			<input type="text"/>		
	<input type="text"/>			<input type="text"/>		
5 Nationality	<input type="text"/>			<input type="text"/>		
6 Country of residence	<input type="text"/>			<input type="text"/>		
7 E-mail address	<input type="text"/>			<input type="text"/>		
8 Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9 Marital status	<input type="text"/>			<input type="text"/>		



SECTION 1 – LIFE (LIVES) ASSURED

Life Assured 1

Life Assured 2 (if applicable)

10 What is your height?

ft in or cm

ft in or cm

11 What is your weight?

st lbs or kg

st lbs or kg

Have you recently lost or gained any weight?

Yes No

Yes No

If Yes, please give details.

Details

Details

12 a) Have you resided, worked or travelled to a different country from your current country of residence or within the last five years?

Yes No

Yes No

(If your only previous country of residence or work has been the United Kingdom, you may answer the question 'No'.)

If Yes, please give details.

Details

Details

12 b) Do you intend to reside, work or travel to a different country from your current country of residence in the next five years? (If you are intending only to reside in the United Kingdom in future, you may answer the question 'No'.)

Yes No

Yes No

If Yes, please give details.

Details

Details

13 Have you taken part in any hazardous sports or pastimes within the last 5 years, or do you intend to start doing so? (Mountaineering, motor sports, horseriding, skiing and private flying are examples, but you should include any activity that is hazardous)

Yes No

Yes No

If Yes, please give details

Details

Details

14 Have you used any form of tobacco or nicotine products in the last 12 months?

Yes No

Yes No

If Yes, please state how much a day.

Cigarettes Cigars

Cigarettes Cigars

Other method oz or gms

Other method oz or gms

15 How much alcohol do you drink? 1 unit = a single measure of spirits or 1 glass of wine or 1/2 pint of beer.

Units per week

Units per week

Have you ever been advised to stop drinking on medical grounds?

Yes No

Yes No

16 Name and address of your doctor.

Telephone

Telephone

SECTION 1 – LIFE (LIVES) ASSURED

Life Assured 1

Life Assured 2 (if applicable)

17 Have you applied to any other company for life insurance, or insurance against 'critical illness' in the last 12 months or are you about to do so?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Company
Details
Dates

Company
Details
Dates

18 Have you ever applied for life insurance, insurance against 'critical illness' or income protection/disability insurance, and been turned down or asked to pay a higher premium or other special terms imposed?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Company
Details
Dates

Company
Details
Dates

SECTION 2 – PLAN OWNER(S) OR APPLICANT(S)

Definition: The Applicant(s) is (are) the person(s) in whose ownership the Plan is to be issued.

Who is/are the Applicant(s) Life Assured 1 Life Assured 2 Both Lives Assured Other*

* If 'Other' please complete the rest of section 2
(If left blank, we will assume that the Applicant(s) is (are) the same as the Life (Lives) Assured)

Applicant 1

Applicant 2 (if applicable)

1 Title

Mr	<input type="checkbox"/>	Mrs	<input type="checkbox"/>	Miss	<input type="checkbox"/>
Other Please Specify	<input type="text"/>				

Mr	<input type="checkbox"/>	Mrs	<input type="checkbox"/>	Miss	<input type="checkbox"/>
Other Please Specify	<input type="text"/>				

2 Surname

3 First name(s)

4 Current 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"/>

5 Nationality

6 Country of residence

7 E-mail address

8 Relationship to, or nature of interest in the Life (Lives) to be Assured

SECTION 3 – CORRESPONDENCE ADDRESS

All communications will be sent to the address of Applicant 1. If you do not wish this to be the case, please provide a correspondence address here.

SECTION 4 – PLAN DETAILS

Plan Name	Level Term						
Please tick the Box <input checked="" type="checkbox"/> for Plan required	Homebuyer Protection						
What is the amount of Life Cover you require?	£						
How long do you want your Plan to run?		Years					
Amount of Premium	£	payable	<table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; padding: 2px;">Monthly</td> <td style="border: 1px solid black; width: 50px; text-align: center;"> </td> <td style="border: 1px solid black; padding: 2px;">Annually</td> <td style="border: 1px solid black; width: 50px; text-align: center;"> </td> </tr> </table>	Monthly		Annually	
Monthly		Annually					
Method of payment	Direct Debit						
	Cheque (if annual)						
	Charge Card						

SECTION 5 – TRUST FACILITIES

Please tick 'Yes' if you wish the Plan to be written under Trust from outset.
 (If 'Yes', a fully completed trust form is required before the policy may commence.
 If left blank, we will assume that you do not require the Plan to be written under Trust.)

Yes	
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SECTION 6 – DETAILS OF YOUR MORTGAGE

Is this plan to be in conjunction with your mortgage?	Yes		No		
Is there anyone else involved in this mortgage but who is not applying for this Plan?	Name			Relationship	

SECTION 7 – STATEMENT OF HEALTH

Please answer each of the following questions ticking boxes where appropriate.

If the answer to any question is ‘Yes’ please give full details disclosing all material facts as they can influence the assessment and acceptance of this application.

If you are in any doubt as to whether any fact is material, you should disclose it, as a failure to do so may invalidate a future claim.

In accordance with the Association of British Insurers’ policy on genetics and insurance, you do not need to tell us about any genetic test result you have had if this application for insurance, taken together with any other insurance policies you already have, for this type of insurance, totals to:

- £500,000 or less for life insurance;

Above these limits, you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government’s Genetics and Insurance Committee (GAIC) has approved them for insurers to use. If you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at www.abi.org.uk/consumer2/disclosure.htm.

However, you must tell us if you either have a family history of, are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition.

If you wish to disclose to us a negative genetic test result, which shows that you have not inherited a genetic disorder, we will take this into account in setting your premium, providing your clinical geneticist confirms that the results indicates a reduced risk of developing the inherited disease.

Life Assured 1

Life Assured 2 (if applicable)

1 In connection with your physical or mental health, have you within the last two years, had any medical consultation (eg with a doctor, psychiatrist, consultant, hospital, clinic, osteopath, etc), investigation, test, drugs or any other treatment or are you awaiting any?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Date
Reason
Doctor/Hospital
Treatment

Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------------	-----------------------------

Date
Reason
Doctor/Hospital
Treatment

2 a) Have you ever tested positive for HIV/AIDS or are you awaiting the results of such a test?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Date
Doctor/Clinic

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Date
Doctor/Clinic

b) Have you ever been tested/ treated for more than one episode of a sexually transmitted disease?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Date
Doctor/Clinic
Reason
Result

Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------------	-----------------------------

Date
Doctor/Clinic
Reason
Result

SECTION 7 – STATEMENT OF HEALTH

Life Assured 1

Life Assured 2 (if applicable)

3 Do you suffer from or have you ever suffered from any of the following:

- | | | | | | | | | | |
|--|-----|--|----|--|--|-----|--|----|--|
| - Heart or circulatory disorder, stroke, high blood pressure or raised cholesterol? | Yes | | No | | | Yes | | No | |
| - Diabetes, kidney or bladder disorder, stomach, bowel or liver disorder (including any form of hepatitis), hernia, gynaecological disorder, any respiratory disorder (including asthma or bronchitis) or any skin disorder? | Yes | | No | | | Yes | | No | |
| - Cancer, any other tumour, lump or growth? | Yes | | No | | | Yes | | No | |
| - Muscular or joint disorder (including arthritis, backache or pain), multiple sclerosis, paralysis, numbness or tingling, or any disorder affecting your eyes, ears, balance or co-ordination? | Yes | | No | | | Yes | | No | |
| - Mental or nervous illness or disorder (including anxiety or depression) or any fatigue, fits or fainting? | Yes | | No | | | Yes | | No | |

Please give details below, including disorders, dates, duration of illness, treatment, results of investigations and tests and time off work.

SECTION 7 – STATEMENT OF HEALTH

Life Assured 1

Life Assured 2 (if applicable)

4 Have your natural parents, brothers or sisters suffered before the age of 65 from any of the following:

- Heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, multiple sclerosis, brain disorder or disorder of the nervous system or any hereditary illness?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Relationship
Disease (including type of cancer if applicable)
Age at time

Relationship
Disease (including type of cancer if applicable)
Age at time

5 Apart from the answers given above, do you suffer from any disability, medical condition, or mental or physical impairment?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Condition
Duration
Time off work

Condition
Duration
Time off work

SECTION 8 – DECLARATION OF LIFE (LIVES) ASSURED

This Declaration must be signed by both people if two people are involved in this Application.
 I/We hereby declare that any information and advice about this product given by my/our financial adviser

(name of financial adviser)

was given only following my/our approach to the financial adviser requesting information and advice on life assurance contracts offered by Friends Provident International.

This Application is my official request to enter into a Term Assurance Plan with Friends Provident International on their normal terms and conditions for the benefits that have been explained to me.

I am not residing in the United Kingdom and confirm that to the best of my knowledge and belief I am not subject to any legislation which would make this plan unlawful.

I understand that details of these terms and conditions and a copy of this completed Application is available on request.

I have read and understood the Important Notes Section of this Application.

I agree that if this Application is in joint names, the answers that I and the second person have given will form the basis of this contract.

I have read my answers to the questions in this Application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no relevant fact has been withheld.

I understand that I must tell Friends Provident International without delay if my health or circumstances change before Life Cover starts.

I accept that if I am required to have a medical examination, my replies to the medical examiner's questions will form part of this Application.

I authorise Friends Provident International to pass medical information to any life insurance company, to any medical examiner, or to any company arranging these examinations on Friends Provident International's behalf.

† I have read about my rights regarding access to medical reports in the Important Notes section and agree that Friends Provident International may ask for information from any Doctor who has attended me or from any company to whom I have applied for life assurance and I authorise the giving of such information during and after my lifetime. I do not * wish to see any medical report before it is sent to Friends Provident International.

I agree that Friends Provident International may ask for any information from any Doctor who has attended me or from any company and I authorise the giving of such information during and after my lifetime.

I consent (subject where applicable to my rights regarding access to medical reports set out in the Important Notes) to Doctors and other medical personnel, hospitals, clinics, social insurance offices and other insurance companies giving any information, case records, registration documents and certificates which Friends Provident International may find necessary in order to issue this policy and in order to handle any future claims on the policy proceeds.

† applicable where your Doctor is registered in the United Kingdom

applicable where your Doctor is not registered in the United Kingdom

* please delete the word 'not' if you do wish to see a medical report before it is sent by the Doctor to Friends Provident International

I accept Friends Provident International will use the information I give for administration, underwriting, claims, research and statistical purposes. I agree Friends Provident International may pass information about my/our physical or mental health or condition to medical practitioners and reinsurers for these purposes.

I also agree Friends Provident International may pass the information to third parties for the prevention or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

I also agree Friends Provident International may pass the information to other companies in the Friends Provident Group* who may use it to advise me of other products and services that may interest me. If you would prefer not to receive such information, please tick this box.

*The Friends Provident Group means Friends Provident plc and any other company in which it has directly or indirectly a material shareholding.

Signature of first life assured	<input type="text"/>	Dated	<input type="text"/>
Signature of second life assured (if applicable)	<input type="text"/>	Dated	<input type="text"/>

SECTION 9 – DECLARATION OF PLAN OWNER(S) OR APPLICANT(S)

This Declaration must be signed if the Plan owner(s) or Applicant(s) are not the Life (Lives) Assured.

This Application is my official request to enter into a Term Assurance Plan with Friends Provident International on their normal terms and conditions for the benefits that have been explained to me.

I understand that details of these terms and conditions and a copy of this completed Application are available on request.

I have read and understood the Important Notes Section of this Application.

I have read the answers to the questions in this Application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no relevant fact has been withheld.

I accept that if the person or people on whose life/lives I am applying for this Plan are required to have a medical examination, their replies to the medical examiner's question will form part of this Application.

I understand that I must tell Friends Provident International without delay if the person or people on whose life/lives I am applying for this Plan should have a change in health or circumstances before Life Cover starts.

I am not residing in the United Kingdom and confirm that to the best of my knowledge and belief I am not subject to any legislation which would make this plan unlawful.

I accept Friends Provident International will use the information I give for administration, underwriting, claims, research and statistical purposes.

I also agree Friends Provident International may pass the information to third parties for the prevention or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

I also agree Friends Provident International may pass the information to other companies in the Friends Provident Group* who may use it to advise me of other products and services that may interest me. If you would prefer not to receive such information, please tick this box.

*The Friends Provident Group means Friends Provident plc and any other company in which it has directly or indirectly a material shareholding.

Signature of first applicant	<input type="text"/>	Dated	<input type="text"/>
Signature of second applicant (if applicable)	<input type="text"/>	Dated	<input type="text"/>

PAYMENT METHODS

GUIDANCE NOTES: Please complete in BLOCK CAPITALS the section which is appropriate for your method of payment and return the form to your Financial Adviser or Friends Provident International. **DO NOT** return the completed form to your Bank or Building Society.

CHARGE CARD AUTHORITY

(Where you are not able to make payments from an account linked to the UK clearing system)

Until further notice in writing, I authorise Friends Provident International to charge my MASTERCARD/VISA/EUROCARD* account a single unspecified sum followed by £ on or immediately after / / (please insert date) and ANNUALLY/MONTHLY* thereafter. (*delete as appropriate.)

Card number	<input type="text"/>	Expiry date	<input type="text"/> / <input type="text"/>	Dated	<input type="text"/> / <input type="text"/> / <input type="text"/>
Cardholder's name	<input type="text"/>	Signature	<input type="text"/>		
Address	<input type="text"/>		For Friends Provident International use only.		
	<input type="text"/>		Policy Number/Collection reference		
	<input type="text"/>		<input type="text"/>		

DIRECT DEBIT INSTRUCTION

Instruction to your Bank or Building Society to pay Direct Debits.

Please fill in the whole form and send it to:

FRIENDS PROVIDENT
PO BOX 1550
MILFORD, SALISBURY
WILTSHIRE SP1 2TW

Originators Identification Number

9 9 0 4 5 7



1. Name and full postal address of your Bank or Building Society

To: The Manager	Bank or Building Society
Address	
Postcode	

2. Name(s) of Account Holder(s)

3. Branch sort code (from the top right hand corner of your cheque) - -

4. Bank or Building Society account number

5. Friends Provident reference number

6. Instruction to your Bank or Building Society
Please pay Friends Provident Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Friends Provident and if so, details will be passed electronically to my Bank/Building Society.

Signature(s)	Date
<input type="text"/>	<input type="text"/>

Bank and Building Societies may not accept Direct Debit Instructions for some types of account.

This guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change Friends Provident will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Friends Provident or your Bank or Building Society you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

SECTION 10 – NON MORTGAGE RELATED PLANS

If your application is assessed and accepted on our normal terms then, unless you have stated below a date on which you would like your cover to start or have instructed us otherwise, we will start your cover immediately.

If your application is not accepted on our normal terms, the cover will start when we receive written confirmation of your acceptance of the revised terms.

We also need to have received your first premium payment or a completed Direct Debit instruction or Charge Card authority.

Effective Date

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SECTION 11 – MORTGAGE RELATED PLANS

When the Life Cover and Plan will Start

If you are taking out a new mortgage and your application has been assessed and accepted on our normal terms;

You are entitled to Free Life Cover which will start when:

- you have a definite contract for the purchase of a property (eg you have exchanged contracts or when improvements or repair work has actually begun)

and

- you have received a letter from your lender offering you a mortgage

The amount of Free Life Cover is limited to the amount of your mortgage up to a maximum of £200,000.

Once the Life Cover has started, please let us know when you would like the Plan to start. This must be within three months of the start of the Life Cover and is usually the completion date of your mortgage. If the Plan does not start within this three month period, your mortgage will no longer be covered if you die.

We also need to have received your first payment or a completed Direct Debit Instruction or Charge Card authority before we can start the Plan.

If your application is not accepted on our normal terms, the Life Cover and Plan will start when the conditions stated above are met and we have written confirmation of your acceptance of the revised terms.

IMPORTANT NOTES

You should disclose all material facts as they can influence the assessment of this Application. If you are in any doubt as to whether any fact is important, you should disclose it, as failure to do so may invalidate a future claim.

* Key Features Leaflets

If you have signed this Application in the United Kingdom and you are not habitually resident in any member state of the European Union or the European Economic Area you should have received a 'Key Features Leaflet' and an illustration for this Plan. Please speak to your Financial Adviser if you have not already received this.

* Smoker status

To qualify for 'non-smoker' status rates you (or both of you in the case of a joint-life plan), must not have used any form of tobacco or nicotine products in the last 12 months. We reserve the right to check the accuracy of your reply if you indicate on this application that you do not smoke.

* Access to Medical Reports (Applicable where your Doctor is registered in the UK)

In order to consider your Application it may be necessary to obtain a report from a Doctor who has attended you. We are required to tell you about your statutory rights regarding access to medical reports which, briefly, are that you can:

- Refuse to allow us to obtain a report, in which case we are unable to proceed.
- Ask to see a report before it is sent to us, or for a charge, obtain a copy from the Doctor within six months.
- Ask that a report you have seen is altered by the Doctor before it is sent to us or if the Doctor is unwilling to do this, you may add a statement of your own.

Please note that the Doctor does not have to let you see a report if he believes you or others would be harmed by it, or it includes confidential material about or given by another person without that person's consent. At all times you have the right to refuse to allow a report to be issued.

If we do need a Doctor's report and you state in this application that you wish to see it before it is posted, we shall let you know when we request the report from the doctor. You will then have twenty one days in which to contact the doctor and arrange to see it.

* Medical Examination

You may not need a medical examination if there is nothing in your personal or family history which we consider relevant provided certain limits are satisfied. We can give you more details about this if you wish. However, you should be aware that Friends Provident International reserves the right to ask you to have a medical examination.

* Terms and Conditions

Full details of the terms and conditions of all Friends Provident International's Plans are available on request from any of our Offices

* Confidentiality

Friends Provident International has a Confidentiality Policy in place which means that your medical information is held securely and access is limited to authorised individuals who need to see it. You are entitled to ask for a copy of our Confidentiality Policy.

PART B – TO BE COMPLETED BY THE FINANCIAL ADVISER

FINANCIAL ADVISER DETAILS

Company name and address
(or stamp)

Name of Regulatory Authority
(where applicable)

Ref. No.

Country where advice given

Country where Application was signed

FINANCIAL ADVISER DECLARATION

I confirm that I have seen documentary proof of the identity of the Applicant(s) in accordance with the provisions of the European Council Directive 91/308/EEC, and relevant national legislation.

First Applicant

Second Applicant

Type of document seen

(eg ID card, Passport, Driving Licence)

Reference number of document shown

(Should have a unique reference number)

I have identified the Applicants and confirm that I have seen the original documents(s) specified above.

I have enclosed a copy of the Applicant's identification documents (compulsory for advisers in non-EU Member countries).

Signed

Name

Dated

Signed

Name

Dated

APPLICATION CHECKLIST

Please use the following section to ensure that this application is processed without unnecessary delay.

Application Form complete, signed and dated by applicant(s)? Yes

Financial Adviser Details complete? Yes

Non Mortgage related plans complete? Yes

Financial Adviser Declaration complete? Yes

Illustration attached? Yes To follow Not applicable

Cheque enclosed? Yes To follow Not applicable

Charge Card authority or Direct Debit instruction complete? Yes To follow Not applicable

Trust Form attached? Yes To follow Not applicable



**FRIENDS PROVIDENT
INTERNATIONAL**

Member of The Association of International Life Offices

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E-mail fp.int@friendsprovident.co.uk Website www.fpinternational.com*

Friends Provident International is the trading name of Friends Provident Life and Pensions Limited for business conducted outside the United Kingdom

Registered and Head Office: Pixham End, Dorking, Surrey RH4 1QA England

Incorporated company limited by shares and registered in England number 4096141

Member of the Friends Provident Marketing Group and regulated in the United Kingdom by the Financial Services Authority

The rules and regulations made by the Financial Services Authority for the protection of investors will not normally apply to persons resident outside the United Kingdom