

Important notes

Please describe as much information about your health as possible before signing this form. All questions asked are relevant, and by providing full and accurate information you will allow an insurer to provide as accurate a quotation as possible. The amount of your annuity income will be based on the medical information supplied. However an insurer may also seek to obtain independent verification of this information from your doctor. If it is subsequently found that the questions were not answered accurately and with reasonable care, then that could result in your income being reduced or your policy being cancelled.

Enhanced Pension Annuity Quotation Request Form

You/Dependant to complete sections 1+2

Please ensure you complete and sign the Declaration and Consent page at the end of Section 2.

Financial Adviser to complete sections 3+4



For more information visit www.retirementhealthform.co.uk
(this includes details on how to complete this Quotation Request Form).

Quote Reference No. (if applicable)

Source of quote

Section 1: Personal Details – To be completed by you

Please complete this form using black ink and capital letters

	Your details	Your dependant's details
Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other
If 'other' please specify	<input type="text"/>	<input type="text"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Surname	<input type="text"/>	<input type="text"/>
Forename(s)	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/> _ <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ <input type="text"/> _ <input type="text"/> _	<input type="text"/> _ <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ <input type="text"/> _ <input type="text"/> _
National Insurance number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>
Marital Status	Single <input type="checkbox"/> Married/Civil Partnership <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	Single <input type="checkbox"/> Married/Civil Partnership <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Relationship to the dependant	<input type="text"/>	<input type="text"/>
Present occupation	<input type="text"/>	<input type="text"/>
If no longer working, previous occupation	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="text"/>	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="text"/>
Date ceased	<input type="text"/> _ <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ <input type="text"/> _ <input type="text"/> _	<input type="text"/> _ <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ / <input type="text"/> _ <input type="text"/> _ <input type="text"/> _ <input type="text"/> _
Are you living	<input type="checkbox"/> In own home – alone <input type="checkbox"/> In own home – with someone else <input type="checkbox"/> With relatives <input type="checkbox"/> In a residential home <input type="checkbox"/> In a care home	<input type="checkbox"/> In own home – alone <input type="checkbox"/> In own home – with someone else <input type="checkbox"/> With relatives <input type="checkbox"/> In a residential home <input type="checkbox"/> In a care home
Home address	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>
Daytime telephone number	<input type="text"/>	<input type="text"/>
Evening telephone number	<input type="text"/>	<input type="text"/>
E-mail address	<input type="text"/>	<input type="text"/>

Has Power of Attorney been vested in another party? Yes No **If yes, please enclose the appropriate documentation**

If so which type?

Now please complete the medical assessment form in Section 2 and any other questionnaire as directed.
A medical assessment form for the dependant will only be required if they are suffering from a condition, and questionnaires may be required, as directed.
If you have a Financial Adviser, please request them to fill in sections 3 and 4.

Section 2: Medical Assessment Form – To be completed by you

Please ensure that all details entered are accurate to improve your benefits.

	Your details	Your dependant's details
Height	<input type="text"/> ft <input type="text"/> ins or <input type="text"/> cms	<input type="text"/> ft <input type="text"/> ins or <input type="text"/> cms
Weight	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kgs	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kgs
Waist measurement	<input type="text"/> ins or <input type="text"/> cms	<input type="text"/> ins or <input type="text"/> cms
Do you currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please advise year started	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Have you been a regular daily smoker for the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are a regular smoker, please indicate the average daily level	<input type="text"/> Manufactured cigarettes <input type="text"/> Cigars	<input type="text"/> Manufactured cigarettes <input type="text"/> Cigars
If you are a regular smoker, please indicate the average weekly level	<input type="text"/> Ozs rolling tobacco or <input type="text"/> Gms rolling tobacco <input type="text"/> Ozs pipe tobacco or <input type="text"/> Gms pipe tobacco	<input type="text"/> Ozs rolling tobacco or <input type="text"/> Gms rolling tobacco <input type="text"/> Ozs pipe tobacco or <input type="text"/> Gms pipe tobacco
If you previously smoked, please advise of the years you started and stopped	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
How much did you smoke?	<input type="text"/> Manufactured cigarettes (daily) <input type="text"/> Cigars (daily) <input type="text"/> Ozs/gms rolling tobacco (weekly) <input type="text"/> Pipe (weekly)	<input type="text"/> Manufactured cigarettes (daily) <input type="text"/> Cigars (daily) <input type="text"/> Ozs/gms rolling tobacco (weekly) <input type="text"/> Pipe (weekly)
How many units of alcohol do you drink weekly?	<input type="text"/>	<input type="text"/>
	(a unit of alcohol is equivalent to half a pint of normal strength beer, lager, or cider, one standard glass of wine, or a single measure of spirit)	
Have you been diagnosed with high blood pressure (hypertension)? If yes, specify date of diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
If yes, specify last readings(s)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Date of reading(s)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Number and name(s) of medication(s) prescribed (excluding aspirin)	<input type="text"/>	<input type="text"/>
Have you been diagnosed with high cholesterol? If yes, specify date of diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
If yes, specify last reading(s)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Date of reading(s)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Number and name(s) of medication(s) prescribed	<input type="text"/>	<input type="text"/>

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Medical Conditions

If you have ever been diagnosed with any of the following please only complete the relevant questionnaire(s).

- Heart condition page 4
- Diabetes page 6
- Cancer, leukaemia, lymphoma, growth, or tumour page 7
- Stroke – please also complete the Activities of Daily Living questionnaire pages 9 & 13
- Respiratory/lung disease page 10
- Multiple sclerosis – please also complete the Activities of Daily Living questionnaire pages 11 & 13
- Neurological disease – please also complete the Activities of Daily Living questionnaire pages 12 & 13

Other Medical Conditions

For any conditions showing within the Medical Conditions area above, please complete the relevant questionnaire(s). For any other conditions, please complete the questions below (and, if relevant, the Activities of Daily Living questionnaire on page 13).

	Your details	Your dependant's details
Condition 1	<input type="text"/>	<input type="text"/>
Condition 2	<input type="text"/>	<input type="text"/>
Condition 3	<input type="text"/>	<input type="text"/>

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a. When were you first diagnosed with this condition?	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y
b. When did you last experience symptoms for this condition?	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y
c. When did you last receive medication/treatment for this condition?	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y
d. When were you last admitted to hospital for this condition?	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y	<input type="text"/> M M / <input type="text"/> Y Y

e. How many times have you been hospitalised for this condition? Please put a figure in the relevant box.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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f. Have you received any of the following treatments for this condition within the past 5 years? Please tick box.

None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please specify	<input type="text"/>			<input type="text"/>		

9-	Your current medication	Dose prescribed	Frequency
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>

	Dependant's current medication	Dose prescribed	Frequency
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>

Heart attack, angina and other heart conditions questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate heart conditions questionnaire if one is required for both you and the dependant.

Have you ever been diagnosed with any of the following?

Diagnosis	Date of diagnosis	No. of occurrences	Ongoing?
Heart attack (Myocardial Infarction)			
Angina			
Heart failure			
Aortic aneurysm			
Cardiomyopathy			
Heart valve disorders			
Atrial fibrillation (AF)			
Other irregular heart rhythm			
Other: _____			

Does your heart condition CURRENTLY affect you in any of the following ways?

	Never	Some of the time	Most of the time	Always
Symptoms at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness walking from room to room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains on minor to moderate activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains on severe exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If surgery has been carried out, please state type of procedure and date of most recent surgery.

Coronary artery bypass graft (CABG)	<input type="checkbox"/>	Number of arteries treated	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Coronary angioplasty/stents	<input type="checkbox"/>	Number of arteries treated	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Aortic valve replacement	<input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		<input type="text"/> / <input type="text"/> / <input type="text"/>
Mitral valve replacement	<input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		<input type="text"/> / <input type="text"/> / <input type="text"/>
Tricuspid valve replacement	<input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		<input type="text"/> / <input type="text"/> / <input type="text"/>
Pacemaker	<input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		<input type="text"/> / <input type="text"/> / <input type="text"/>
Cardioversion/ablation	<input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		<input type="text"/> / <input type="text"/> / <input type="text"/>
Aortic aneurysm repair	<input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date		<input type="text"/> / <input type="text"/> / <input type="text"/>

What medication are you CURRENTLY taking? Please list all medication prescribed for your heart condition:

Name of medication	Name of heart condition	Dose prescribed	Frequency	Date medication commenced
1				
2				
3				
4				
5				

Please enclose copies of any available hospital letters or reports about your heart condition

Are you currently under the care of a cardiologist? Yes No Last consultation date: / / /

Name of cardiologist

Name of hospital

How many times have you been admitted to hospital due to your heart condition within the past 10 years?

Never Once Twice Three times More than three times

Date of last admission / / /

Is any future treatment planned? Yes No If yes, please give details:

Please advise date and result of any stress (exercise) ECG testing e.g. using a bicycle or treadmill.

Date	Result (Normal / Abnormal / Other)

Please provide any further information you think may be important. (e.g dates of multiple surgery)

Diabetes questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate diabetes questionnaire if one is required for both you and the dependant.

Please enclose copies of any available hospital letters or reports about your diabetes.

When was your diabetes diagnosed? Date /

Is your diabetes? Type 1 Type 2

How is your diabetes controlled? Diet only Non-insulin (tablet/injection) Insulin

Please list all the medication you CURRENTLY take, and how often you take each of them, the dosage and date medication commenced.

Medication	Dose prescribed	Date started

If this has changed, please advise your PREVIOUS treatment regimen.

Medication	Dosage	Date started	Date stopped

Have you been diagnosed with any of the following DIABETIC complications? If yes, please give details in the box provided below.

- Heart disease
- Retinopathy (excluding other eye disease)
- Neuropathy
- Kidney disease (protein in urine)
- Peripheral vascular disease (with ulceration)
- Amputation

Please give the last two readings for HbA1c:

Reading 1

Date: / /

Reading 2

Date: / /

Have you ever been admitted into hospital AS A RESULT OF YOUR DIABETES? Yes No If yes, when? /

How often do you monitor your own blood glucose levels?

Number of times

Frequency (please tick as appropriate)

- daily weekly fortnightly four-weekly
- monthly quarterly half yearly annually

Please provide any further information you think may be important.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate questionnaire if one is required for both you and the dependant. If you have a history of more than one type of cancer please complete a separate questionnaire for each.

What is the name or type of the tumour/malignant condition?

Where was the tumour located?

When was the tumour/condition first diagnosed?

Was the tumour:

Benign

Pre-cancerous

Malignant

Do you know the staging of the tumour?

Please tick as appropriate

Stage

TNM

Modified Astler-Coller (MAC)

Figo classification

Dukes classification

Clark level

Breslow thickness

Ann Arbor classification

Do you know the grading of the tumour?

Yes

No

If yes, please give details:

PLEASE ENCLOSE COPIES OF ANY HOSPITAL LETTERS OR REPORTS ABOUT YOUR CANCER TO CONFIRM THE TYPE OF CANCER, STAGE, GRADE, AND TREATMENT RECEIVED.

Please tick the box that most closely describes the nature of the tumour

Carcinoma-in-situ (stage O, Tis, Ta)

Only local tumour growth

Tumour invaded adjacent lymph nodes

Tumour invaded distant lymph nodes

If yes, please advise number of nodes affected and location

Tumour spread to distant organs (distant metastases) If so, where

In the case of prostate cancer, please advise where known

Current Prostate Specific Antigen (PSA) level

Date recorded:

Pre-treatment PSA level

Date recorded:

Gleason Score

Date recorded:

In the case of breast cancer, please advise where known

Breast Cancer Hormone Receptor Status

Did you have, or are you due to have, any of the following as a result of your tumour or malignant condition (eg. Leukaemia):

Surgery

Type of surgery:

Date: $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Chemotherapy

Date commenced $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Date ended: $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Radiotherapy (including brachytherapy)

Date commenced $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Date ended: $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Bone marrow/stem cell transplant

Date commenced $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Date ended: $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Hormone therapy

Date commenced $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Date ended: $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Other
(eg. BCG, HIFU, Immunotherapy)

(Please give full details and advise of date of treatment)

Has there been any recurrence in the same location? Yes No If yes, please advise date, staging, treatment:

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced
1			
2			
3			
4			
5			

When was your last tumour follow-up appointment with your treating doctor/hospital consultant: $\frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$

Have you now been discharged? Yes No

Please provide any further information you think may be important.

Stroke questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate stroke questionnaire if one is required for both you and the dependant.

Please enclose copies of any hospital letters or reports about your stroke(s).

Please advise which of the following you have been diagnosed with:

CVA (Cerebrovascular Accident – major stroke)

SAH (Subarachnoid Haemorrhage)

Cerebral haemorrhage/bleed

TIA (Transient Ischaemic Attack – mini stroke)

Episode/type (e.g.CVA, TIA)	Date	Part of body affected	Duration of initial symptoms	Duration until full recovery

Please advise of any of the following ongoing problems due to your stroke:

Speech difficulties

Vision impairment Paralysis arm

Paralysis leg

Short-term memory loss

What medication are you CURRENTLY taking for this condition?

Name of medication	Dose prescribed	Frequency	Date commenced
1			
2			
3			
4			
5			

Are you under follow-up or have you now been discharged? Still under follow-up Discharged

Name of your consultant

Name of hospital

Please provide any further information you think may be important.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 13

Respiratory/lung disease questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate respiratory/lung disease questionnaire if one is required for both you and the dependant.

Please advise which of the following you have been diagnosed with:

- Chronic obstructive airways/pulmonary disease (COAD/COPD)
- Emphysema
- Bronchiectasis
- Pneumoconiosis (a type of lung disease related to occupation)
- Asbestosis
- Asthma
- Pleural plaques
- Sleep apnoea

Date of diagnosis

/
 /
 /
 /
 /
 /
 /
 /

Other

Please specify

Is your current lung function:

Unaffected

Yes No

Minimally impaired (FEV1 greater than 70%)

Yes No

Moderately impaired (FEV1 50-70%)

Yes No

Severely impaired (FEV1 less than 50%)

Yes No

Do any of the following apply due to your respiratory lung condition? Never Some of the time Most of the time Always

Chest infections

Need for home oxygen

Need for a continuous positive airway pressure (CPAP) breathing machine

Signs of cor pulmonale (right heart failure due to lung disease)

Breathlessness walking from room to room

Breathlessness climbing stairs

Breathlessness when lying flat

Oral steroids (in tablet form only e.g. Prednisolone)

Have you been admitted to hospital for your respiratory/lung disease?

Never Once More than once

Last admission /

What medication are you currently taking for your respiratory/lung disease?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Please provide any further information you think may be important.

Multiple sclerosis questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate multiple sclerosis questionnaire if one is required for both you and the dependant.

When was your Multiple Sclerosis diagnosed?

 / / /
M M Y Y

Please advise subtype, if known:

Relapsing remitting

Secondary progressive

Primary progressive

Progressive relapsing

Please advise number of attacks in the last 5 years:

What medication are you currently taking?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Have you been admitted to hospital due to your multiple sclerosis?

Never Once More than once

Last admission / / /
M M Y Y

Do you have, or have you had, any of the following in relation to your multiple sclerosis?

Bladder incontinence/self-catheterisation

Yes No

Secondary infection (eg. pneumonia)

Yes No

Progressive mental deterioration

Yes No

Impairment of vision

Yes No

Impairment of speech

Yes No

Paralysis of a limb

Yes No

Use of steroids (eg. prednisolone) on more than 1 occasion

Yes No

Please provide any further information you think may be important.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 13

Other neurological condition questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate neurological questionnaire if one is required for both you and the dependant.

Please advise which of the following you have been diagnosed with:

- Senile dementia
- Vascular dementia
- Alzheimer's disease
- Parkinson's disease
- Motor neurone disease

Date of diagnosis

M	M	/	Y	Y
M	M	/	Y	Y
M	M	/	Y	Y
M	M	/	Y	Y
M	M	/	Y	Y

Other Please specify (including date of diagnosis)

Have you been admitted to hospital due to your neurological condition? Never Once More than once

Last admission / / /

Do you have, or have you had, any of the following symptoms in relation to your neurological condition?

- | | | |
|----------------|------------------------------|-----------------------------|
| Pressure sores | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Falls | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tremors | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What medication are you currently taking in relation to your neurological condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Please advise last MMSE (Mini Mental State Examination) score if known /30

Please provide any further information you think may be important.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 13

Activities of Daily Living (ADL) questionnaire

Please indicate who is completing

You:

Your Dependant:

Name:

Please complete a separate ADL questionnaire if one is required for both you and the dependant.

Please advise relevant diagnosis in relation to which you are completing this questionnaire:

Please tick one box from each of the following that most closely reflects your current condition

Dressing:

- Independent (including buttons, zips, laces etc.)
- Needs help, but can do about half unaided
- Dependent, requires full assistance

Mobility:

- Independent (needs no assistance)
- Walks with assistance (frame/stick etc.)
- Wheelchair use – non-permanent
- Wheelchair use – permanent
- In need of daily nursing care
- Bedridden

Transferring:

- Independent
- Minor help, can sit unaided
- Major help
- Unable, no sitting balance

Bladder:

- Continent
- Occasional accident (once a week)
- Incontinent/catheterised/unable to manage alone

Bowels:

- Continent
- Occasional accident (once a week)
- Incontinent (or requires enema)

Bathing:

- Independent
- Needs some assistance
- Dependent

Feeding:

- Independent
- Needs some help cutting, spreading butter etc.
- Unable (nasogastric tube/PEG tube in place)

Please advise any progression in the last 5 years:

- Rapid deterioration
- Deteriorating (impact to 2 or more ADLs above/acute episodes)
- Stable (no/minimal change)

Data Protection Act 1998

The information provided on this form, together with medical and other information about you provided in connection with this application, will be used for the operation of insurance which covers you.

This includes the process of underwriting, administration, claims management, rehabilitation and customer concern handling. In order to do this the information may be shared with group companies and third party insurers, re-insurers, insurance intermediaries and service providers.

Your data will be processed fairly and securely in accordance with the Data Protection Act 1998. Details of your rights under the Act, the data which the Provider holds, the data which may be passed to organisations outside of the Provider and the organisations which might be involved, can be obtained by writing to the Providers' Data Protection Officer.

Your personal data will be available to only those who need to see it. For example, sensitive data, such as medical records, will be used for the purposes of underwriting or claim management and rehabilitation and will be seen only by the people authorised by the Providers' Medical Officer or equivalent.

Please note that you are explicitly consenting to the processing of your medical data by signing and returning this document.

You are entitled to receive a copy of all your personal data held by contacting either your Financial Adviser or the Provider.

Please note that during the processing of any proposals and administration, information may be transferred outside the European Economic Area. You are consenting to this transfer by signing and returning this document.

Notice of Statutory Rights

Under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Access to Health Records and Reports (Isle of Man) Act 1993 the Provider reserves the right to apply for a medical report from any doctor who has at any time attended you. The declaration gives us your consent to apply for such a report if we need to.

Your rights:

- You do not have to give your consent but, without it, the Provider will not be prepared to accept your request.
- If you do give your consent, you can indicate whether or not you wish to see any report before it is sent to us.

If you indicate that you do not wish to see any report:

- The doctor can forward it to us immediately and we should be able to process your proposal without delay.
- You can, however, still change your mind at any time within six months and notify the doctor that you wish to see the report. If the doctor has already forwarded the report to us, he/she will send you a copy and, if not, he/she will give you 21 days to arrange to see it.

If you indicated that you do wish to see any report:

- This may delay the processing of your proposal.
- The doctor is allowed to charge you a fee to cover the cost of supplying you with the report.
- You should follow the procedures outlined below.

Procedures for Access to Reports

1. If you indicate that you do wish to see any report we will notify you if we apply for one, and will inform the doctor of your wishes. You will then have 21 days to contact the doctor to arrange to see the report.
2. If you do see the report, the doctor must obtain your consent before sending it to us.
3. You have the right to request that the doctor amends any part of a report you consider incorrect or misleading, and can attach your written views on any part the doctor refuses to amend.
4. The doctor does not have to let you see any part of a report that he/she considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his/her intentions towards you. He/she also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report he/she must notify you of that fact.

Declaration and Consent

Please read, complete and sign this section.

I/We declare that the information and statements provided above are true and I/we have taken reasonable care to ensure that my/our answers to the questions asked are correct. I/We understand that if any information provided by me/us is subsequently found to be inaccurate the policy may be amended or cancelled in accordance with the Consumer Insurance (Disclosure and Representations) Act 2012. I understand that this may mean the benefits payable to me/us are reduced and in some instances the policy may be cancelled.

I/We agree that the Provider may obtain medical information from any doctor who, at any time, has attended me/us, about anything that affects my/our physical or mental health and/or any insurance office to which a proposal has been made on my/our life and I/we authorise the giving of such information. This consent shall remain valid throughout the duration of the insurance and after my/our death unless I/we advise the Provider otherwise.

I/We agree that the Provider may apply for medical evidence. I/We authorise the Provider to pass medical information to any medical officer on the Providers behalf.

YOU – I do do not wish to see the report before it is sent to the Provider

YOUR DEPENDANT – I do do not wish to see the report before it is sent to the Provider

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

I/We agree the Provider 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/We agree that a copy of this declaration and consent can be treated as the original.

I/We agree to the Provider processing my/our medical data.

I/We understand that I/we must inform the Provider without delay if there is a change to my/our health or circumstances before the commencement of the policy. I/We understand that failure to do so may result in amendment or cancellation of the policy in accordance with the Consumer Insurance (Disclosure and Representations) Act 2012.

I/We have been duly notified of my/our rights under the Access to Medical Information legislation as detailed overleaf governing access to medical records.

The information provided in this form will be shared with Aviva, Canada Life, Just, Legal & General and Retirement Advantage to allow them to provide you with an Annuity quotation. These Providers will share your personal and medical information and, if applicable, your dependant's personal and medical information contained in this form with other companies to obtain a market leading comparison quote (in accordance with Financial Conduct Authority regulations) to see if you could receive more annuity income with another provider.

YOU – I/We do do not consent for my/ our personal and medical information to be shared with other companies for the purpose of obtaining a market leading comparison quote (in accordance with Financial Conduct Authority regulations).

The Provider reserves the right to decline any requests.

The Provider is not on risk until a policy is issued by the Provider.

I/We have read and understood the notice regarding the Data Protection Act 1998 overleaf.

	YOU	DEPENDANT
Doctor's Name	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Telephone number	<input type="text"/>	<input type="text"/>
Fax number	<input type="text"/>	<input type="text"/>

	YOU	DEPENDANT
Name (BLOCK CAPITALS)	<input type="text"/>	<input type="text"/>
Signature	<input type="text"/>	<input type="text"/>
Date	<u> </u> / <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>	<u> </u> / <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>

Section 3: Financial Adviser's Details

If you have a Financial Adviser, this section should be completed by them.

What was the basis of sale (please tick)	<input type="checkbox"/> Advised – Independent	<input type="checkbox"/> Non-Advised – Execution Only
	<input type="checkbox"/> Advised – Restricted	<input type="checkbox"/> Non-Advised – No Advice
	<input type="checkbox"/> Advised – Simplified	<input type="checkbox"/> Non-Advised – Direct Offer
Name of Firm	<input type="text"/>	
Contact Name	<input type="text"/>	
RI/Adviser Name	<input type="text"/>	
Company Address	<input type="text"/>	
Postcode	<input type="text"/>	
E-mail	<input type="text"/>	
PRA and/or FCA Reference Number	<input type="text"/>	
Telephone Number	<input type="text"/>	
Facsimile Number	<input type="text"/>	

Adviser Remuneration

Please note that a copy of the Service Agreement will need to be provided at the point of application.

a) Adviser Charge

Initial Adviser Charge facilitated by the annuity provider

Not to be facilitated by the annuity provider

£ (Monetary Amount)
or
 % (Percentage)

Where should the Initial Adviser Charge be deducted from (please tick)?

Total purchase money*

Purchase money after the payment of any Pension Commencement Lump Sum (tax free cash)*

Pension Commencement Lump Sum (tax free cash)**

* Please note this is only available from providers who support these options.
**Please note that if Adviser Charge is deducted from Pension Commencement Lump Sum this will reduce the amount paid to the client. This is only available from providers who support this option.

On-going Adviser Charge facilitated by the annuity provider***

£ (Monetary Amount) and (Frequency)
or
 % (Percentage)

*** Please note this is only available with products that support this option.

b) Commission (only available on Non-Advised Sales)

£ (Monetary Amount)
or
 % (Percentage)
or
 Nil Commission

How would you prefer to receive the quote? Post Fax Email

CONFIDENTIAL

- The Providers who receive this completed form may use some of the information to advise you by post, telephone or e-mail of other products or services offered by themselves or by their business partners. If you do not wish to receive this material please tick this box.
- Please note that during the processing of any application and administration, information may be transferred outside the European Economic Area.

For a full explanation regarding confidentiality, please read the data protection statement on page 14.

Section 4: Pension Details

If you have a Financial Adviser, please ask them to assist you with the completion of this page.

Note: Not all of the life offices may offer these options, for example RPI escalation may only be available from certain offices. You will need to contact each office for more information. Please photocopy this page if you are requesting multiple quotes.

Only complete one box

Total purchase price Before payment of pension commencement lump sum (tax free cash)
 Net amount after payment of pension commencement lump sum (tax free cash)
 Income required The quote will calculate the purchase price required to secure the specified income amount.

Source of funds

Name of ceding pension provider/s

Protected Pension Commencement Lump Sum (Tax Free Cash) above 25%? Yes No

Pension Commencement Lump Sum (Tax Free Cash) required? Yes No (tax free cash already paid)

If yes, please give amount, if less than 25%

Registered pension scheme Yes No

Death in service Yes No

Pensions credit Yes No

Assumed annuity commencement date D D / M M / Y Y Y Y

Pension benefits

If applicable GMP/GAR Annual Income

Benefit Type	Income (Per annum)	From (Date or Age)	Escalation rate	Revaluation rate
GAR	<input type="text" value="£"/>	<input type="text"/>		
GMP (Pre 06/04/1988)	<input type="text" value="£"/>	<input type="text"/>	<input style="width: 50px;" type="text" value="%"/>	<input style="width: 50px;" type="text" value="%"/>
GMP (Post 05/04/1988)	<input type="text" value="£"/>	<input type="text"/>	<input style="width: 50px;" type="text" value="%"/>	<input style="width: 50px;" type="text" value="%"/>
Section 92b Rights	<input type="text" value="£"/>	<input type="text"/>		

Annuity options

Payable Yearly Half Yearly Quarterly Monthly (maximums will vary by provider)
 In advance In arrears
 With proportion Without proportion
 With overlap Without overlap

Escalation 3% 5% RPI LPI Other
 Guarantee None 5 Years 10 Years Other

Payable as lump sum, if possible Yes No

Value Protection % please specify the percentage of the purchase price to be protected

Value Protection (Joint Lives) Payment on spouse death Payment on annuitant's death

With dependant's benefit Yes No

% dependants benefit on death 33.3% 50% 66.7% 100% Other

Ceasing on remarriage Yes No

Single life and joint life Yes No

Number of illustrations expected

This assumes that the annuitant's fund is within the lifetime allowance.

If above LTA, please state the level of protection