Section 1: **Personal Details**

To be completed by you and your dependant.
Please complete this form using black ink and capital letters

	Your details	Your dependant's details
Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other
If 'other' please specify		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Forename(s)		
Surname		
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Marital Status	☐ Single ☐ Married/Civil Partnership ☐ Separated ☐ Divorced ☐ Widowed	☐ Single ☐ Married/Civil Partnership ☐ Separated ☐ Divorced ☐ Widowed
Relationship to the dependant		
Present occupation		
If no longer working, previous occupation	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time
Date ceased	M M / Y Y	M M / Y Y
Are you living	☐ In own home – alone ☐ In own home – with someone else ☐ With relatives ☐ In a residential home ☐ In a care home	☐ In own home – alone ☐ In own home – with someone else ☐ With relatives ☐ In a residential home ☐ In a care home
House name/number		
Address		
Postcode		
Email address		

NOW PLEASE COMPLETE THE MEDICAL ASSESSMENT FORM IN SECTION 2 AND ANY OTHER QUESTIONNAIRE AS DIRECTED.

Section 2: **Medical Assessment**

To be completed by you and your dependant.
Please ensure that all details entered are accurate to improve your benefits.

	Your details	Your dependant's details
1. Height	☐ ft ☐ ins **or** ☐ cms	☐ ft ☐ ins **or** ☐ cms
2. Weight	☐ st ☐ lbs **or** ☐ kgs	☐ st ☐ lbs **or** ☐ kgs
3. Waist measurement	☐ ins **or** ☐ cms	☐ ins **or** ☐ cms
4. Do you currently smoke?	☐ Yes ☐ No	☐ Yes ☐ No
a) If yes, please advise month/year started	M M / Y Y	M M / Y Y
b) Have you been a regular **daily** smoker for the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
c) If you are a regular smoker, please indicate the average **daily** level	☐ Manufactured cigarettes ☐ Cigars	☐ Manufactured cigarettes ☐ Cigars
d) If you are a regular smoker, please indicate the average **weekly** level	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)
5. If you previously smoked, please advise of the months/years you started and stopped	M M / Y Y M M / Y Y	M M / Y Y M M / Y Y
a) If you were a regular cigarette and/or cigar smoker, please indicate the average **daily** level	☐ Manufactured cigarettes ☐ Cigars	☐ Manufactured cigarettes ☐ Cigars
b) If you were a regular rolling tobacco/or pipe smoker, please indicate the average **weekly** level	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)
6. How many units of alcohol do you drink **weekly**?	☐	☐

Guidance Note: A unit of alcohol is equivalent to half a pint of normal strength beer, lager, or cider, one small (125ml) glass of wine, or a single measure of spirit.

7. Have you been diagnosed with high blood pressure (hypertension)? ☐ Yes ☐ No ☐ Yes ☐ No

a) If yes, specify date of diagnosis M M / Y Y M M / Y Y

b) If yes, specify last readings(s)

Guidance Note: Blood pressure readings required are those taken by your GP/Clinician rather than home self-testing kits.

c) Date of reading(s) M M / Y Y M M / Y Y M M / Y Y M M / Y Y

d) Name(s) of medication(s) prescribed (excluding aspirin)

8. Have you been diagnosed with high cholesterol? ☐ Yes ☐ No ☐ Yes ☐ No

a) If yes, specify date of diagnosis M M / Y Y M M / Y Y

b) If yes, specify last reading(s)

Guidance Note: Cholesterol readings required are those taken by your GP/Clinician rather than home self-testing kits.

c) Date of reading(s) M M / Y Y M M / Y Y M M / Y Y M M / Y Y

d) Name(s) of medication(s) prescribed

IMPORTANT NOTES

The amount of your annuity income will be based on the medical information supplied. 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. 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.

Medical Conditions

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

Other Medical Conditions

For any other conditions, please complete the questions below (and, if relevant, the Activities of Daily Living questionnaire on page 16). If you or your dependant have more than 3 conditions, please use a separate form to submit details of the other conditions.

	Your details			Your dependant's details		
Condition 1						
Condition 2						
Condition 3						
	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a. When were you first diagnosed with this condition?	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y
b. When did you last experience symptoms for this condition?	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y
c. When did you last receive medication/treatment for this condition?	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y
d. When were you last admitted to hospital for this condition?	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y	__/__ M M / Y Y

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

f. Have you received any of the following treatments for this condition within the PAST 5 YEARS? Please tick box.

None	☐	☐	☐	☐	☐	☐
Renal dialysis	☐	☐	☐	☐	☐	☐
Surgery	☐	☐	☐	☐	☐	☐
Please specify						

g.

Your current medication	Dosage	Frequency
1		
2		
3		

Dependant's current medication	Dosage	Frequency
1		
2		
3		

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.
Please refer to any available hospital letters or reports about your heart condition to complete this section.
You may also include copies of any reports with your request form.

Have you ever been diagnosed with any of the following?

Diagnosis	Date of diagnosis (MM/YY)	No. of occurrences	Condition ongoing? (yes/no)
Heart attack (Myocardial Infarction)			Not Applicable
Angina			
Heart failure			
Aortic aneurysm			
Cardiomyopathy			
Heart valve disorders			
Atrial fibrillation (AF)			
Other irregular heart rhythm			
Other: please specify (e.g. blocked artery) _____			

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	☐	☐	☐	☐
Breathlessness walking from room to room	☐	☐	☐	☐
Breathlessness climbing stairs	☐	☐	☐	☐
Chest pains on minor to moderate activity	☐	☐	☐	☐
Chest pains on severe exertion	☐	☐	☐	☐
Swollen ankles	☐	☐	☐	☐
Episodes of dizziness	☐	☐	☐	☐
Episodes of blackouts	☐	☐	☐	☐

If surgery has been carried out, please state type of procedure and date of MOST RECENT surgery.

Coronary artery bypass graft (CABG)	☐	Number of arteries treated ☐	Date __/__ (M M / Y Y)
Coronary angioplasty/stents	☐	Number of arteries treated ☐	Date __/__ (M M / Y Y)
Aortic valve replacement	☐	Successful? ☐ Yes ☐ No	Date __/__ (M M / Y Y)
Mitral valve replacement	☐	Successful? ☐ Yes ☐ No	Date __/__ (M M / Y Y)
Tricuspid valve replacement	☐	Successful? ☐ Yes ☐ No	Date __/__ (M M / Y Y)
Pacemaker	☐	Successful? ☐ Yes ☐ No	Date __/__ (M M / Y Y)
Cardioversion/ablation	☐	Successful? ☐ Yes ☐ No	Date __/__ (M M / Y Y)
Aortic aneurysm repair	☐	Successful? ☐ Yes ☐ No	Date __/__ (M M / Y Y)

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

Medication name	Name of heart condition(s)	Dosage	Frequency	Date commenced (MM/YY)
1				
2				
3				
4				
5				

Are you currently under the care of a cardiologist? ☐ Yes ☐ No Last consultation date: __/__ (M M / Y Y)

How many times have you been admitted to hospital due to your heart condition WITHIN THE 10 PAST YEARS?

Number of hospital admissions ☐ Date of last admission __/__ (M M / Y Y)

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.
(Do not include resting ECG tests.)

Date	Result
	Normal / Abnormal / Other **(Please delete as appropriate)**

Please provide any further information you think may be relevant e.g. dates of multiple surgery, or other surgery types not covered above (please specify).

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 refer to any available hospital letters or reports about your diabetes to complete this section.
You may also include copies of any reports with your request form.

When was your diabetes diagnosed? __/__ (M M / Y Y)

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 for your diabetes?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

Have you been diagnosed with any of the following DIABETIC complications? If yes, please select as appropriate giving details with dates 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: (Please record readings either as mmol/mol or as a percentage)

Guidance Note: HbA1c readings can be reported as mmol/mol or as a percentage. Mmol/mol readings are usually higher figures between 40 mmol/mol and 140+ mmol/mol; whereas percentage readings are usually lower figures between 3.0% and 16.0%. (Please do not advise results of glucose finger prick tests, fasting blood sugar tests or random blood sugar tests here.)

HbA1c Reading 1 _____ mmol/mol or _____ % Date: __/__ (M M / Y Y)

HbA1c Reading 2 _____ mmol/mol or _____ % Date: __/__ (M M / Y Y)

Have you ever been admitted into hospital AS A RESULT OF YOUR DIABETES? ☐ Yes ☐ No If yes, when? __/__ (M M / Y Y)

If you monitor your own blood glucose levels how frequently do you monitor it? Number of times ☐

Frequency (please tick as appropriate)

☐ daily ☐ weekly ☐ fortnightly ☐ monthly ☐ quarterly ☐ half yearly ☐ annually

Please provide any further information you think may be important.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please refer to and/or include any available hospital letters or reports about your cancer, stage, grade and treatment received to complete this section.

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 and its location?

_____

When was the tumour/malignant condition first diagnosed? __/__ (M M / Y Y)

Was the tumour: ☐ Benign ☐ Pre-cancerous ☐ Malignant

If you know the clinically confirmed staging of the tumour, please tick and provide details against the relevant classification below:

General Classification (used for all cancers e.g. Stage 1B):

Stage: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Sub-stage (1-4 only) ☐ A ☐ B ☐ C

TNM (commonly used for most cancers e.g. T1aN0M0)

T Stage ☐ Ta ☐ Tis ☐ TX ☐ T0 ☐ T1 ☐ T2 ☐ T3 ☐ T4 Sub-stage (T1-T4 only) ☐ a ☐ b ☐ c

N Stage ☐ NX ☐ N0 ☐ N1 ☐ N2 ☐ N3 Sub-stage (N1-N3 only) ☐ a ☐ b ☐ c

M Stage ☐ MX ☐ M0 ☐ M1

Dukes classification (used for colorectal cancers)

Stage: ☐ A ☐ B ☐ C ☐ D

Modified Astler-Coller (MAC) (used for colorectal cancers):

Stage ☐ A ☐ B1 ☐ B2 ☐ B3 ☐ C1 ☐ C2 ☐ C3 ☐ D

Figo classification (used for gynaecological cancers)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Clark level (used for skin cancers, specifically malignant melanomas)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Breslow thickness (used for skin cancers, specifically malignant melanomas)

Details: _____ mm

Ann Arbor classification (used for lymphomas)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Do you know the clinically confirmed grade of the tumour? ☐ Yes ☐ No

If yes, please tick appropriate option ☐ Grade 1 (Low) ☐ Grade 2 (Intermediate) ☐ Grade 3 (High)

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
If ticked, please advise number of nodes affected and location

☐ Tumour invaded distant lymph nodes
If ticked, please advise number of nodes affected and location

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

Guidance Note: The removal of lymph nodes for biopsy does not necessarily mean the cancer has spread there.

In the case of PROSTATE CANCER, please advise where known

Current Prostate Specific Antigen (PSA) level — Date: __/__ (M M / Y Y)

Pre-treatment PSA level — Date: __/__ (M M / Y Y)

Gleason Score — Date: __/__ (M M / Y Y)

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:

☐ Surgery — Type of surgery: — Date: __/__ (M M / Y Y)

☐ Chemotherapy — Date commenced: __/__ (M M / Y Y) — Date ended: __/__ (M M / Y Y)

☐ Radiotherapy (including brachytherapy) — Date commenced: __/__ (M M / Y Y) — Date ended: __/__ (M M / Y Y)

☐ Bone marrow/stem cell transplant — Date commenced: __/__ (M M / Y Y) — Date ended: __/__ (M M / Y Y)

☐ Hormone therapy — Date commenced: __/__ (M M / Y Y) — Date ended: __/__ (M M / Y Y)

☐ Other *(Please give full details)*
(e.g. BCG, HIFU, Immunotherapy) — Date: __/__ (M M / Y Y)

What medication are you CURRENTLY taking for this condition?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

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

When was your last tumour follow-up appointment with your treating doctor/hospital consultant? ___/___
M M Y 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 refer to any available hospital letters or reports about your stroke(s) to complete this section.
You may also include copies of any reports with your request form.

Please advise which of the following you have been diagnosed with and give details of all episodes below:

☐ 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 (i.e. number of hours or days)	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?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

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

Please provide any further information you think may be important.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 16

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 refer to/include any available hospital letters or reports as necessary.

Please advise which of the following respiratory conditions you have been diagnosed with: Date of diagnosis:

☐ Chronic obstructive airways/pulmonary disease (COAD/COPD)	__/__ M M / Y Y
☐ Emphysema	__/__ M M / Y Y
☐ Bronchiectasis	__/__ M M / Y Y
☐ Pneumoconiosis (a type of lung disease related to occupation)	__/__ M M / Y Y
☐ Asbestosis	__/__ M M / Y Y
☐ Asthma	__/__ M M / Y Y
☐ Pleural plaques	__/__ M M / Y Y
☐ Sleep apnoea	__/__ M M / Y Y
☐ Other Please specify _____	__/__ M M / Y Y

How has your lung function been graded according to FEV1? (This does not refer to Peak Flow):

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)	☐	☐	☐	☐

If you have been admitted to hospital for your respiratory/lung disease, how many times have you been admitted and please indicate date of last admission?

Number of hospital admissions ☐ Date of last admission __/__ M M / Y Y

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

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

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. Please refer to any available hospital letters or reports about your multiple sclerosis to complete this section. You may also include copies of any reports with your request form.

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?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			

If you have been admitted to hospital due to your multiple sclerosis, please indicate how many times you have been admitted and the date of your last admission?

Number of hospital admissions ☐ Date of 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 (e.g. pneumonia)	☐ Yes	☐ No
Progressive mental deterioration	☐ Yes	☐ No
Vision impairment	☐ Yes	☐ No
Speech impairment	☐ Yes	☐ No
Paralysis of a limb	☐ Yes	☐ No
Use of steroids (e.g. 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 16

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 refer to any available hospital letters or reports about your other neurological conditions to complete this section. You may also include copies of any reports with your request form.

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

☐ Vascular dementia — Date of diagnosis: __/__ (M M / Y Y)

☐ Alzheimer's disease — Date of diagnosis: __/__ (M M / Y Y)

☐ Dementia (not otherwise specified above) — Date of diagnosis: __/__ (M M / Y Y)

☐ Parkinson's disease — Date of diagnosis: __/__ (M M / Y Y)

☐ Motor neurone disease — Date of diagnosis: __/__ (M M / Y Y)

☐ Other Please specify _____ — Date of diagnosis: __/__ (M M / Y Y)

If you have been admitted to hospital for your neurological condition, how many times have you been admitted and please indicate date of last admission?

Number of hospital admissions ☐ Date of last admission __/__ (M M / Y Y)

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

Pressure sores ☐ Yes ☐ No

Falls ☐ Yes ☐ No

Tremors ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

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

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			

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

Please provide any further information you think may be important, e.g. the result of any other cognition assessment.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 16

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: How is your ability to dress yourself?

- ☐ I am able to fully dress myself (including buttons, zips, laces etc.)
- ☐ I am able to dress myself but require some assistance with buttons, zips and laces etc.
- ☐ I require full assistance to dress myself

Mobility Indoors: How easily you can move from one place to another?

- ☐ I can independently move from one place to another
- ☐ I walk with assistance (frame/stick/rolling walker)
- ☐ I use a wheelchair some of the time
- ☐ I use a wheelchair always
- ☐ I require full assistance of one or two people
- ☐ I am bedridden

Transferring: How well are you able to move from one position to another, e.g. from a chair to a bed?

- ☐ I am able to get into a chair or bed independently
- ☐ I require the assistance or supervision of one person to get into a chair or bed
- ☐ I require the assistance of two people to get into a chair or bed
- ☐ I am unable to transfer and require a hoist to transfer

Bladder Control: How would you describe your current bladder control?

- ☐ I am in full control of my bladder
- ☐ I have occasional accidents
- ☐ I am unable to control my bladder or I am catheterised

Bowel Control: How would you describe your current bowel control?

- ☐ I am in full control of my bowel movements
- ☐ I have occasional accidents
- ☐ I have no control of my bowel movements

Bathing and Showering: How easy is it for you to bathe and get in and out of the bath or shower?

- ☐ I can independently wash and bathe myself
- ☐ I can wash independently but require assistance in and out of the bath or shower
- ☐ I require full assistance to bathe or shower

Feeding: What is your current ability to feed yourself once food has been prepared and made available?

- ☐ I can independently feed myself
- ☐ I require assistance to cut up the food on my plate but I am able to feed myself
- ☐ I am unable to feed myself or require a naso-gastric/ PEG tube

How has your ability to perform your ADL changed over the last 5 years?

- ☐ I have experienced no change; or deterioration in only one activity
- ☐ I have experienced deterioration in two or more activities
- ☐ I have experienced deterioration in two or more activities within the last 12 months

Current Data Protection Laws and Future Legislation

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. You can understand how we use and share your personal data by reading and retaining the generic Privacy Notice accompanying this application (page 24) or reviewing each Provider's full Privacy/ Data Protection Notice from their website. Their web addresses are on the first page of the accompanying Privacy Notice.

Your data will be processed fairly and securely in accordance with current Data Protection laws and future legislation and may be passed to organisations outside of the Provider for the provision of underwriting, administration, claims management, rehabilitation and customer concern handling services and may also be shared with group companies and third party insurers, re-insurers, insurance intermediaries and service providers.

Furthermore, your 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 Provider's Medical Officer or equivalent.

Your personal data will only be available to those who need that information and you have the right to receive a copy of all your personal data held by contacting either your Financial Adviser, the Provider or by writing to the Provider's Data Protection Officer.

Please note that during the processing of any proposals and administration, information may be transferred outside the European Economic Area.

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

Has Power of Attorney been vested in another party?

☐ Yes ☐ No *If yes, please enclose the appropriate documentation*

If so, which type? ☐

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 Provider's behalf.

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 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 in accordance with the Privacy Notice, a copy of which has been provided to me/us.

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.

I/We understand that 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.

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

The information provided in this form will be shared with Aviva, Canada Life, Just, Legal & General and Scottish Widows 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 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 Privacy Notice regarding the Data Protection Legislation on page 24.

	YOU	YOUR DEPENDANT
Doctor's Name		
Surgery Address		
Telephone number		
Fax number		
	YOU	YOUR DEPENDANT
Name (BLOCK CAPITALS)		
Signature		
Date of Signature	__ __/__ __/__ __ __ __ D D M M Y Y Y Y	__ __/__ __/__ __ __ __ D D M M Y Y Y Y