# Section 1: Personal Details - **To be completed by the Annuitant**

| | 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 |
| Surname | | |
| Forename(s) | | |
| Date of birth | (dd/mm/yyyy) | (dd/mm/yyyy) |
| National Insurance number | | |
| Nationality | | |
| Marital Status | Single ☐ Married/Civil Partnership ☐ Separated ☐ Divorced ☐ Widowed ☐ | Single ☐ Married/Civil Partnership ☐ Separated ☐ Divorced ☐ Widowed ☐ |
| Is second life | ☐ Spouse ☐ Dependant | |
| Present occupation | | |
| | ☐ Full-time ☐ Part-time | ☐ Full-time ☐ Part-time |
| If no longer working, previous occupation | | |
| Date ceased | (dd/mm/yyyy) | (dd/mm/yyyy) |
| Home address | | |
| Postcode | | |
| Daytime telephone number | | |
| Evening telephone number | | |
| E-mail address | | |

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 two 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.

**Sections 3 and 4 need to be completed by your Financial Adviser**

# Section 2: Medical Assessment Form - **To be completed by the Annuitant**

Please disclose as much information about your health and lifestyle as possible before signing this form. An annuity may commence on the basis of the medical information supplied. Failure to answer questions about your health fully, accurately and truthfully may result in any annuity enhancement being reduced or removed in full which means you will receive standard annuity rates. If you are unsure about details of any material facts or dates, check the details to ensure they are accurate to the best of your knowledge and belief. A report from your doctor may be obtained subsequently but it remains your responsibility to complete the application form accurately.

**Please enclose copies of any available hospital letters and a copy of your latest repeat prescription form, if possible.**

Name: _____ Date of Birth: _____

Sex: M F Height: ft ____ ins ____ or cms ____ Weight: st ____ lbs ____ or kgs ____

Waist measurement: ____ Dress size: ____ Trouser size: ____

Do you currently smoke? ☐ Yes ☐ No ☐ Never

If you are a regular cigarette smoker and have been for the last 10 years, please indicate the average daily level.

Smokers: ____ Cigarettes per day ____ Cigars per day ☐ Hand-rolled ☐ Pipe tobacco ____ ozs per week

If previously smoked, please advise of the years you started and stopped: _____ to _____

How much **did** you smoke: ____ Cigarettes per day ____ Cigars per day ☐ Hand-rolled ☐ Pipe tobacco ____ ozs per week

How many units of alcohol do you drink weekly? _____

*(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)*

Are you currently living: ☐ in own home ☐ in care home ☐ living alone in own home ☐ with someone else

**Please now complete the tick box section on page 5 and answer the questions below.**
**Please do not forget to complete a supplementary questionnaire if applicable.**

- ☐ **Heart attack, angina or any other heart condition** — please complete the questionnaire on page 7
- ☐ **Diabetes** — please complete the questionnaire on page 9
- ☐ **Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour** — please complete the questionnaire on page 10
- ☐ **Stroke** — please complete the questionnaire on page 12
- ☐ **High blood pressure or high cholesterol** — please specify, provide latest reading if possible and treatment received
- ☐ **Chronic respiratory disease** — name of condition, treatment required, impact on daily living
- ☐ **Kidney or liver disease** — specify type of disease, list investigations, whether dialysis required
- ☐ **Multiple sclerosis** — specify any mobility restrictions (e.g. wheelchair bound), severity of condition, investigations and treatment required
- ☐ **Alzheimer's disease, dementia or Parkinson's disease** — specify symptoms, treatment, assistance required and any complications e.g. pressure sores
- ☐ **Any other serious illness or condition** — please give full details below

**Please do not forget to complete the additional questionnaire for your relevant medical condition/s.**

**Please state exact condition, date of diagnosis, treatment/medication and dosage required. Please give full details of any hospitalisation and whether you are suffering symptoms, their frequency and severity. Include any relevant family history.** *(Please note, the more information you provide us with the better the enhancement we may be able to offer you.)*

# Medical Assessment Form - **To be completed by the Dependant, only if a joint life annuity is required**

Please disclose as much information about your health and lifestyle as possible before signing this form. An annuity may commence on the basis of the medical information supplied. Failure to answer questions about your health fully, accurately and truthfully may result in any annuity enhancement being reduced or removed in full which means you will receive standard annuity rates. If you are unsure about details of any material facts or dates, check the details to ensure they are accurate to the best of your knowledge and belief. A report from your doctor may be obtained subsequently but it remains your responsibility to complete the application form accurately.

**Please enclose copies of any available hospital letters and a copy of your latest repeat prescription form, if possible.**

Name: _____ Date of Birth: _____

Sex: M F Height: ft ____ ins ____ or cms ____ Weight: st ____ lbs ____ or kgs ____

Waist measurement: ____ Dress size: ____ Trouser size: ____

Do you currently smoke? ☐ Yes ☐ No ☐ Never

If you are a regular cigarette smoker and have been for the last 10 years, please indicate the average daily level.

Smokers: ____ Cigarettes per day ____ Cigars per day ☐ Hand-rolled ☐ Pipe tobacco ____ ozs per week

If previously smoked, please advise of the years you started and stopped: _____ to _____

How much **did** you smoke: ____ Cigarettes per day ____ Cigars per day ☐ Hand-rolled ☐ Pipe tobacco ____ ozs per week

How many units of alcohol do you drink weekly? _____

*(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)*

Are you currently living: ☐ in own home ☐ in care home ☐ living alone in own home ☐ with someone else

**Please now complete the tick box section on page 5 and answer the questions below.**
**Please do not forget to complete a supplementary questionnaire if applicable.**

- ☐ **Heart attack, angina or any other heart condition** — please complete the questionnaire on page 7
- ☐ **Diabetes** — please complete the questionnaire on page 9
- ☐ **Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour** — please complete the questionnaire on page 10
- ☐ **Stroke** — please complete the questionnaire on page 12
- ☐ **High blood pressure or high cholesterol** — please specify, provide latest reading if possible and treatment received
- ☐ **Chronic respiratory disease** — name of condition, treatment required, impact on daily living
- ☐ **Kidney or liver disease** — specify type of disease, list investigations, whether dialysis required
- ☐ **Multiple sclerosis** — specify any mobility restrictions (e.g. wheelchair bound), severity of condition, investigations and treatment required
- ☐ **Alzheimer's disease, dementia or Parkinson's disease** — specify symptoms, treatment, assistance required and any complications e.g. pressure sores
- ☐ **Any other serious illness or condition** — please give full details below

**Please do not forget to complete the additional questionnaire for your relevant medical condition/s.**

**Please state exact condition, date of diagnosis, treatment/medication and dosage required. Please give full details of any hospitalisation and whether you are suffering symptoms, their frequency and severity. Include any relevant family history.** *(Please note, the more information you provide us with the better the enhancement we may be able to offer you.)*

## For all conditions please complete the questions below

| | Your details | Your dependant's details |
|---|---|---|
| Condition 1 | | |
| Date of diagnosis | (dd/mm/yyyy) | (dd/mm/yyyy) |
| Condition 2 | | |
| Date of diagnosis | (dd/mm/yyyy) | (dd/mm/yyyy) |
| Condition 3 | | |
| Date of diagnosis | (dd/mm/yyyy) | (dd/mm/yyyy) |

If you have more than 3 conditions, please photocopy and provide full details.

1. When did you last receive treatment for this condition? Please tick box.

| | | | | | | |
|---|---|---|---|---|---|---|
| 0-6 months | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 6 months to 1 year | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 1 - 2 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 2 - 3 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 3 - 5 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 5 - 7 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 7 - 9 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| More than 9 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

2. When did you suffer symptoms for this condition? Please tick box.

| | | | | | | |
|---|---|---|---|---|---|---|
| 0-6 months | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 6 months to 1 year | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 1 - 2 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 2 - 3 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 3 - 5 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 5 - 7 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 7 - 9 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| More than 9 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

3. How long ago were you last hospitalised for this condition? Please tick box.

| | | | | | | |
|---|---|---|---|---|---|---|
| 0-6 months | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 6 months to 1 year | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 1 - 2 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 2 - 3 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 3 - 5 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 5 - 7 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 7 - 9 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| More than 9 years | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

| **Your current medication** | **Dose prescribed** | **Frequency** |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

| Your dependant's **current medication** | **Dose prescribed** | **Frequency** |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

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

| | | | | | | |
|---|---|---|---|---|---|---|
| | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

5. How many prescribed medications have you received in the last two years for this condition? Please tick box.

| | | | | | | |
|---|---|---|---|---|---|---|
| None | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 1 daily | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 2 daily | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| 3+ daily | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

6. Have you received any of the following treatments within the past 2 years? Please tick box.

| | | | | | | |
|---|---|---|---|---|---|---|
| None | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Chemotherapy | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Radiotherapy | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Surgery | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Renal dialysis | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

7. Concerning your mobility, in respect of this condition are you…? Please tick box.

| | | | | | | |
|---|---|---|---|---|---|---|
| Fully independent | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Able to walk only with assistance e.g. stick, frame | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Permanently wheelchair bound | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| In need of daily nursing care | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |
| Bedridden | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 | ☐ Cond 1 | ☐ Cond 2 | ☐ Cond 3 |

**If there is any other information you feel may be relevant, please provide details:**

Annuitant: ☐ Dependant: ☐

Name:

**Please complete a separate questionnaire if one is required for both the annuitant and the dependant.**

# Supplementary Questionnaire - Heart attack, angina or any other heart condition

**Only complete if you have indicated on pages 3 and/or 4 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your heart condition.**

**Have you ever been diagnosed with any of the following?**

☐ Heart attack ☐ Aortic aneurysm ☐ Atrial fibrillation (AF)
☐ Angina ☐ Enlarged heart ☐ Heart valve disorders
☐ Heart failure ☐ Cardiomyopathy ☐ Other (please specify)

Please provide full details including date(s) of diagnosis, all subsequent hospital treatments and current symptoms:

If you ticked the box for 'Angina', do you continue to suffer from this? ☐ Yes ☐ No

If 'yes', please give full details:

**If surgery has been carried out, please state type of procedure**

Coronary artery bypass graft (CABG): ☐ How many arteries: Date(s):

Angioplasty/stents: ☐ Number of arteries treated: Date(s):

Other surgery (please give details and date of procedure):

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

| | Never | Occasionally | Always |
|---|---|---|---|
| Breathlessness walking from room to room | ☐ | ☐ | ☐ |
| Breathlessness climbing stairs | ☐ | ☐ | ☐ |
| Chest pains on minor to moderate activity | ☐ | ☐ | ☐ |
| Chest pains on severe exertion only | ☐ | ☐ | ☐ |
| Swollen ankles | ☐ | ☐ | ☐ |
| Episodes of dizziness or blackouts | ☐ | ☐ | ☐ |

**Please give, if known, your latest:**

Blood pressure reading: / Date: Cholesterol reading: Date:

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

| Name of medication | Name of heart condition | Dose prescribed |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

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

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

Are you awaiting the results of any investigations? ☐ Yes ☐ No If yes, please advise for what and date:

**Please provide any further information you think may be important, including any family history of cardiovascular (heart) disease or the date of any stress (exercise) ECG testing, e.g. using a bicycle or treadmill.**

Annuitant: ☐ Dependant: ☐

Name:

**Please complete a separate questionnaire if one is required for both the annuitant and the dependant.**

# Supplementary Questionnaire - Diabetes

**Only complete if you have indicated on pages 3 and/or 4 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your diabetes.**

**When was your diabetes diagnosed?** Date:

**How is your diabetes controlled?**

☐ Diet ☐ Non-Insulin (tablet) ☐ Insulin

Please list all the medication you currently take, and how often you take each of them

If this has changed, please advise your previous treatment regime:

Date altered:

**Do you suffer from any of the following diabetic complications?**

☐ Coronary Heart Disease
☐ Problem with your eyes (retinopathy)
☐ Diabetic Neuropathy (loss of sensation)
☐ Renal Disease (protein in urine)
☐ Elevated blood pressure
☐ Poor circulation

If yes, please give details:

How often do you monitor your own blood glucose levels?

Blood glucose result: fasting/non-fasting Date:

*Please delete as appropriate*

HbA1c: Date:

Cholesterol level: Date:

Blood pressure (BP) reading: Date:

Have you ever been admitted into hospital as a result of your diabetes? ☐ Yes ☐ No If yes, when?

**Please provide any further information you think may be important, including any family history of diabetes if known.**

Annuitant: ☐ Dependant: ☐

Name:

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

# Supplementary Questionnaire

## Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour

**Only complete if you have indicated on pages 3 and/or 4 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any hospital letters or reports about your cancer to confirm the type of cancer, stage, grade and treatment received.**

**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 and/or grading of the tumour, for example TNM or Duke classification?** ☐ Yes ☐ No

If yes, please give details:

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

☐ Only tiny tumour growth (carcinoma in-situ) ☐ Only local tumour growth

☐ Tumour invaded adjacent lymph nodes ☐ Tumour invaded distant lymph nodes

☐ 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:

Gleason Score: Date recorded:

Has there been any spread of the tumour? ☐ Yes ☐ No ☐ Not known

If yes, please describe where:

Has there been any recurrence? ☐ Yes ☐ No If yes, please give details:

**Did you have, or are you due to have, any of the following:**

☐ Surgery

Type of surgery: Date:

☐ Chemotherapy Date commenced: Date ended:

☐ Radiotherapy Date commenced: Date ended:

☐ Bone Marrow Transplant Date commenced: Date ended:

| Medication | Dose/frequency | Date commenced | Date ended |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ Other *(Please give full details)*

When was your last tumour follow-up appointment with your treating doctor/hospital consultant:

Have you now been discharged? ☐ Yes ☐ No

**Please provide any further information you think may be important, including any family history of cancer if known.**

Annuitant: ☐ Dependant: ☐

Name:

**Please complete a separate questionnaire if one is required for both the annuitant and the dependant.**

# Supplementary Questionnaire - Stroke

**Only complete if you have indicated on pages 3 and/or 4 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any hospital letters or reports about your stroke/s.**

**Please advise which of the following you have suffered from:**

☐ CVA (Cerebrovascular Accident — major stroke) ☐ TIA (Transient Ischaemic Attack — mini-stroke)
☐ Subarachnoid Haemorrhage (SAH)

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

**Please tick one box from each of the following that most closely reflects your current condition as a result of your stroke:**

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

**Mobility:**
☐ Bedridden
☐ In need of daily nursing care
☐ Wheelchair dependent
☐ Walks with assistance (frame/stick etc.)
☐ Independent (needs no assistance)

**Transferring:**
☐ Unable, no sitting balance
☐ Major help
☐ Minor help, can sit unaided
☐ Independent

**Bladder:**
☐ Incontinent/catheterised/unable to manage alone
☐ Occasional accident (once a week)
☐ Continent

**Bowels:**
☐ Incontinent (or requires enema)
☐ Occasional accident (once a week)
☐ Continent

**Bathing:**
☐ Dependent
☐ Independent

**Feeding:**
☐ Unable (naso-gastric tube/PEG tube in place)
☐ Needs some help cutting, spreading butter etc.
☐ Independent

**Other residual problems:**
☐ Speech difficulties
☐ Vision impairment
☐ Paralysis arm
☐ Paralysis leg

Please give your last blood pressure (BP) reading, if known: Date:

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

Name of your consultant

Name of hospital

**Please provide any further information you think may be important, including any family history of cerebrovascular disease if known.**

# 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' Chief 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, to the best of my/our knowledge and belief, the statements above are true and complete and that I/we have not withheld any material information. I/we understand that failure to do so may result in amendment of the policy.

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.

I/we agree that this form together with any statements made to the medical officer form the basis of the contract between me/us and the Provider.

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.

I/we understand that the Provider reserves the right to offer revised policy terms should they issue the policy and subsequently find that I/we have failed to disclose material facts or misdisclosed material facts.

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 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 of the policy.

I/we have read and understood my rights under the relevant legislation as detailed overleaf governing access to medical records.

**Please indicate which Provider/s you require annuity quotation terms from:**

☐ Canada Life ☐ Just Retirement ☐ Legal & General ☐ LV= ☐ Norwich Union
☐ MGM Advantage ☐ Partnership ☐ Prudential ☐ Scottish Widows

The Provider/s who receive this completed form, may use some of the information to advise you by post or telephone of other products and services offered by themselves or by their business partners. If you do not wish to receive this material please tick this box. ☐ Annuitant ☐ Dependant

ANNUITANT — I do ☐ do not ☐ wish to see the report before it is sent to the Provider

DEPENDANT — I do ☐ do not ☐ wish to see the report before it is sent to the Provider

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.

| | ANNUITANT | DEPENDANT |
|---|---|---|
| Doctor's Name | | |
| Address | | |
| | | |
| | | |
| Telephone number | | |
| Fax number | | |

| | ANNUITANT | DEPENDANT |
|---|---|---|
| Name (BLOCK CAPITALS) | | |
| Signature | | |
| Date | (dd/mm/yy) | (dd/mm/yy) |

# Section 3: Financial Adviser's Details - **To be completed by the Financial Adviser**

What was the basis of the advice given *(please tick)* ☐ Non-Advised ☐ Advised

Name of Firm

Contact Name

Company Address

Postcode

E-mail

FSA Reference Number

Telephone Number

Facsimile Number

Commission Payable ☐ Full Other ☐ Nil

How would you prefer to receive the quote: ☐ Post ☐ Fax ☐ E-mail

CONFIDENTIAL

1. 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. ☐
2. Please note that during the processing of any applications and administration, information may be transferred outside the European Economic Area.

# Section 4: Pension Details - **To be completed by the Financial Adviser**

**NB: Not all of the life offices may offer these options. Please consult each office for details. Please photocopy this page if you require multiple quotes.**

**Total purchase price** £ before payment of pension commencement lump sum (tax free cash)

*(only complete one box)* £ net amount after payment of pension commencement lump sum (tax free cash)

**Source of funds**

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 ☐ ☐ ☐ (dd/mm/yyyy)

| **Non-protected rights benefits** | Value |
|---|---|
| Pre 06/04/1997 | £ |
| Post 05/04/1997 | £ |

| **Protected rights/contracted out benefits** | Value |
|---|---|
| Pre 06/04/1997 | £ |
| Post 05/04/1997 | £ |

| **GMP/related benefit** | Value | Escalation rate | Revaluation rate |
|---|---|---|---|
| Pre 06/04/1988 | £ | % | |
| Post 05/04/1988 | £ | % | |

**Annuity options**

Payable ☐ Yearly ☐ Half Yearly ☐ Quarterly ☐ Monthly %

☐ In advance ☐ In arrears

☐ With proportion ☐ Without proportion

☐ With overlap ☐ Without overlap

Escalation ☐ 3% ☐ 5% ☐ RPI ☐ LPI ☐ Other

Guarantee ☐ None ☐ 5 years ☐ 10 years (max) ☐ Other

Payable as lump sum, if possible ☐ Yes ☐ No

Value protection % please specify the percentage of the annuity to be protected

Value Protection (Joint Lives) ☐ Payment on spouse death ☐ Payment on annuitants 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

Would you like an enhanced With Profits Annuity quotation? *(only offered by LV= and Prudential)* ☐ Yes ☐ No

If yes, please state the Anticipated Bonus Rate (ABR): ☐ 0% ☐ 3.5% ☐ 5% **or** ☐ other % please specify

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

**Notes:**

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Fax:
01707 671194

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www.canadalife.co.uk/ifazone

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