MEDICAL

Medical Details – Applicant 1 (Annuitant)

It is very important that you disclose as much information about your health as possible before signing this form, as there are several companies in the marketplace that could offer you improved terms on your annuity.

Name _____

Address _____

_____ Postcode _____

Date of birth _____ (DD/MM/YY) Male ☐ Female ☐

Height (ft/ins or cms) _____ Weight (st/lbs or kgs) _____ Waist (inches) _____

Occupation prior to retirement _____

Are you currently living in your own home? ☐ a residential nursing home? ☐ or with relatives? ☐

1. **If you drink alcohol, please state approximate intake per week _____ units**
   (1 pint of beer = 2 units, 1 glass of wine = 1 unit, 1 measure of spirits = 1 unit)
2. **Are you currently a smoker and have you been for the last 10 years?** ☐ Yes ☐ No
3. **Please advise the average number of:**
   Manufactured Cigarettes ☐ Cigars ☐ Pipe Tobacco ☐ Hand Rolled ☐
   a) Average amount per day? _____
   b) If reduced or stopped, please give the date and reasons why _____
   _____
   _____
4. **If you suffer from high blood pressure, please advise:**
   a) BP readings POST medication if known (systolic/diastolic) _____
   b) Names of prescribed medications _____
   c) How many prescriptions/items of medication you take for high blood pressure? _____
5. **If you suffer from high cholesterol, please advise:**
   a) Cholesterol level POST medication (mmol/l) if known _____
   b) Names of prescribed medications _____
   c) How many prescriptions/items of medication you take for high cholesterol? _____
6. **Have you suffered from any of the following:** *(please tick as appropriate)*

	*Yes	No
a) Heart attack	☐	☐
b) Angina	☐	☐
c) Heart bypass/angioplasty ..... *(please delete as appropriate)*	☐	☐
d) Diabetes controlled by ..... diet / tablet / insulin *(please delete as appropriate)* If insulin dependent, please specify number of times taken per day _____	☐	☐
e) Asthma/chronic respiratory ..... disease *(please delete as appropriate)*	☐	☐
f) Cancer	☐	☐
g) Stroke	☐	☐
h) Impaired kidney/ongoing dialysis *(please delete as appropriate)*	☐	☐
i) Bladder/liver complaint ..... *(please delete as appropriate)*	☐	☐
j) Digestive/bowel complaint ..... *(please delete as appropriate)*	☐	☐
k) Multiple Sclerosis ..... Incomplete paralysis/wheelchair bound *(delete as appropriate)*	☐	☐
l) Alzheimer's/Parkinson's disease .... *(please delete as appropriate)*	☐	☐
m) Are you on a waiting list for ..... treatment or awaiting test results?	☐	☐
n) Any other serious illness or ..... condition? *(please specify)* _____	☐	☐

*If yes, please give full details on page 4.

Please tick if additional details have been supplied ☐

Medical Details – Applicant 2 (Dependant)

It is very important that you disclose as much information about your health as possible before signing this form, as there are several companies in the marketplace that could offer you improved terms on your annuity.

Name _____

Address (as per applicant ☐) _____

_____ Postcode _____

Date of birth _____ (DD/MM/YY) Male ☐ Female ☐

Height (ft/ins or cms) _____ Weight (st/lbs or kgs) _____ Waist (inches) _____

Occupation prior to retirement _____

Are you currently living in your own home? ☐ a residential nursing home? ☐ or with relatives? ☐

1. **If you drink alcohol, please state approximate intake per week _____ units**
   (1 pint of beer = 2 units, 1 glass of wine = 1 unit, 1 measure of spirits = 1 unit)
2. **Are you currently a smoker and have you been for the last 10 years?** ☐ Yes ☐ No
3. **Please advise the average number of:**
   Manufactured Cigarettes ☐ Cigars ☐ Pipe Tobacco ☐ Hand Rolled ☐
   a) Average amount per day? _____
   b) If reduced or stopped, please give the date and reasons why _____
   _____
   _____
4. **If you suffer from high blood pressure, please advise:**
   a) BP readings POST medication if known (systolic/diastolic) _____
   b) Names of prescribed medications _____
   c) How many prescriptions/items of medication you take for high blood pressure? _____
5. **If you suffer from high cholesterol, please advise:**
   a) Cholesterol level POST medication (mmol/l) if known _____
   b) Names of prescribed medications _____
   c) How many prescriptions/items of medication you take for high cholesterol? _____
6. **Have you suffered from any of the following:** *(please tick as appropriate)*

	*Yes	No
a) Heart attack	☐	☐
b) Angina	☐	☐
c) Heart bypass/angioplasty ..... *(please delete as appropriate)*	☐	☐
d) Diabetes controlled by ..... diet / tablet / insulin *(please delete as appropriate)* If insulin dependent, please specify number of times taken per day _____	☐	☐
e) Asthma/chronic respiratory ..... disease *(please delete as appropriate)*	☐	☐
f) Cancer	☐	☐
g) Stroke	☐	☐
h) Impaired kidney/ongoing dialysis *(please delete as appropriate)*	☐	☐
i) Bladder/liver complaint ..... *(please delete as appropriate)*	☐	☐
j) Digestive/bowel complaint ..... *(please delete as appropriate)*	☐	☐
k) Multiple Sclerosis ..... Incomplete paralysis/wheelchair bound *(delete as appropriate)*	☐	☐
l) Alzheimer's/Parkinson's disease .... *(please delete as appropriate)*	☐	☐
m) Are you on a waiting list for ..... treatment or awaiting test results?	☐	☐
n) Any other serious illness or ..... condition? *(please specify)* _____	☐	☐

*If yes, please give full details on page 4.

Please tick if additional details have been supplied ☐

Medical Details (both Applicants)

APPLICANT 1

Condition 1 _____

Date of diagnosis _____

Condition 2 _____

Date of diagnosis _____

Condition 3 _____

Date of diagnosis _____

APPLICANT 2

Condition 1 _____

Date of diagnosis _____

Condition 2 _____

Date of diagnosis _____

Condition 3 _____

Date of diagnosis _____

	Applicant 1			Applicant 2		
	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
1. When did you last suffer symptoms or receive treatment for this condition? *(please tick)*						
a) 0 – 6 months ago	☐	☐	☐	☐	☐	☐
b) 7 – 24 months ago	☐	☐	☐	☐	☐	☐
c) 25 – 60 months ago	☐	☐	☐	☐	☐	☐
d) More than 60 months ago	☐	☐	☐	☐	☐	☐
2. How long have you suffered from this condition? *(please tick)*						
a) 0 – 12 months ago	☐	☐	☐	☐	☐	☐
b) 13 – 60 months ago	☐	☐	☐	☐	☐	☐
c) 61 – 120 months ago	☐	☐	☐	☐	☐	☐
d) More than 120 months ago	☐	☐	☐	☐	☐	☐
3. When were you last hospitalised for this condition? *(please tick)*						
a) Never	☐	☐	☐	☐	☐	☐
b) 0 – 12 months ago	☐	☐	☐	☐	☐	☐
c) 13 – 60 months ago	☐	☐	☐	☐	☐	☐
d) More than 60 months ago	☐	☐	☐	☐	☐	☐
4. What treatment have you received in the last two years for this condition? *(please tick)*						
a) Nothing	☐	☐	☐	☐	☐	☐
b) 1-2 prescribed medications daily	☐	☐	☐	☐	☐	☐
c) 3+ prescribed medications daily	☐	☐	☐	☐	☐	☐
d) Special treatment ..... *e.g. surgery, radiotherapy, chemotherapy or renal dialysis*	☐	☐	☐	☐	☐	☐
5. Concerning your mobility, in respect of this condition are you: *(please tick)*						
a) Fully independent	☐	☐	☐	☐	☐	☐
b) Able to walk only with assistance ..... *e.g. stick, frame*	☐	☐	☐	☐	☐	☐
c) Wheelchair bound*	☐	☐	☐	☐	☐	☐
d) In need of daily nursing care*	☐	☐	☐	☐	☐	☐
e) Bedridden*	☐	☐	☐	☐	☐	☐

**permanently and irreversibly*

In some circumstances, particularly where a history of a more serious or recent episode of ill health is indicated, the company/companies may wish to contact your GP to get full details of the condition.
Please note that the company/companies reserve(s) the right to contact your GP to confirm the details given.

Additional Information

APPLICANT 1

What medication are you currently taking? Please list all medication prescribed:

Medication _____ Dose prescribed_____

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

_____ _____

APPLICANT 2 (Spouse / Dependent)

Medication _____ Dose prescribed_____

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

_____ _____

Please give full details including: date of diagnosis, treatment received (with dates), dates of hospitalisation and details of current medication being taken.

The more fully you answer the questions, the more accurate the assessment will be of your eligibility for enhanced rates.