

MERCER

# Medical application form

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## Section 1: Personal Details – to be completed by the Annuitant

### Your details

Title  Mr  Mrs  Miss  Ms  Other

If 'other', please specify

Gender  Male  Female

Surname

Forename(s)

Date of birth    (dd/mm/yyyy)

National Insurance number

Nationality

Marital status Single  Married/civil partnership

Separated  Divorced  Widowed

Relationship to the dependant

Present occupation

Full time  Part time

If no longer working, previous occupation

Date ceased    (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 so which type?

### Your Dependant's details

Mr  Mrs  Miss  Ms  Other

Male  Female



(dd/mm/yyyy)

    


Single  Married/civil partnership

Separated  Divorced  Widowed

Full time  Part time

(dd/mm/yyyy)








*If yes, please enclose the appropriate documentation*

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 he or she is suffering from a condition, and questionnaires may be required, as directed.

## 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 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: Male  Female  Height: ft  in  or cm  Weight: st  lb  or kg

Waist measurement:  Dress size:  Trouser size:

Do you currently smoke?  Yes  No

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

Cigarettes per day  Cigars per day  Hand-rolled  Pipe tobacco  oz 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  oz 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 4 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 6
- Diabetes – please complete the questionnaire on page 8
- Cancer, leukaemia, Hodgkin’s disease, lymphoma, growth or tumour – please complete the questionnaire on page 9
- Stroke – please complete the questionnaire on page 11
- High blood pressure or high cholesterol – please specify, providing 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 any 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 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: Male  Female  Height: ft  in  or cm  Weight: st  lb  or kg   
Waist measurement:  Dress size:  Trouser size:   
Do you currently smoke?  Yes  No

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

Cigarettes per day  Cigars per day  Hand-rolled  Pipe tobacco  oz 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  oz 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 4 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 6
- Diabetes – please complete the questionnaire on page 8
- Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour – please complete the questionnaire on page 9
- Stroke – please complete the questionnaire on page 11
- High blood pressure or high cholesterol – please specify, providing 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 any 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)

Condition 2

Date of diagnosis    (dd/mm/yyyy)

Condition 3

Date of diagnosis    (dd/mm/yyyy)

(dd/mm/yyyy)

(dd/mm/yyyy)

(dd/mm/yyyy)

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

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

|                    |                                 |                                 |                                 |                                 |                                 |                                 |
|--------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 0 – 6 months       | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 6 months to 1 year | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 1 – 2 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 2 – 3 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 3 – 5 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 5 – 7 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 7 – 9 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| More than 9 years  | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
- When did you suffer symptoms for this condition? Please tick box.
 

|                    |                                 |                                 |                                 |                                 |                                 |                                 |
|--------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 0 – 6 months       | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 6 months to 1 year | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 1 – 2 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 2 – 3 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 3 – 5 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 5 – 7 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 7 – 9 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| More than 9 years  | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
- How long ago were you last hospitalised for this condition? Please tick box.
 

|                    |                                 |                                 |                                 |                                 |                                 |                                 |
|--------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 0 – 6 months       | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 6 months to 1 year | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 1 – 2 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 2 – 3 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 3 – 5 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 5 – 7 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 7 – 9 years        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| More than 9 years  | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> 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.
- |  |                                 |                                 |                                 |                                 |                                 |                                 |
|--|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
|  | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
|--|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
5. How many prescribed medications have you received in the last two years for this condition? Please tick box.
- |          |                                 |                                 |                                 |                                 |                                 |                                 |
|----------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| None     | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 1 daily  | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 2 daily  | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| 3+ daily | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
6. Have you received any of the following treatments within the past two years? Please tick box.
- |                |                                 |                                 |                                 |                                 |                                 |                                 |
|----------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| None           | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Chemotherapy   | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Radiotherapy   | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Surgery        | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Renal dialysis | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
7. Concerning your mobility, in respect of this condition are you ...? Please tick box.
- |   |                                 |                                 |                                 |                                 |                                 |                                 |
|---|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Fully independent                                     | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Able to walk only with assistance (e.g. stick, frame) | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Permanently wheelchair bound                          | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| In need of daily nursing care                         | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 |
| Bedridden   | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> Cond 3 | <input type="checkbox"/> Cond 1 | <input type="checkbox"/> Cond 2 | <input type="checkbox"/> 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 2 and/or 3 that you suffer/have suffered from this condition. Please provide as much information as you can. If you are unsure whether something is relevant, put it down anyway, it may be helpful. If you are unsure about 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  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathlessness climbing stairs            | <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"/> |
| Chest pains on severe exertion only       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen ankles                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Episodes of dizziness or blackouts        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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, i.e. 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 2 and/or 3 that you suffer/have suffered from this condition. Please provide as much information as you can. If you are unsure whether something is relevant, put it down anyway, it may be helpful. If you are unsure about 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 it:

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:

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 2 and/or 3 that you suffer/have suffered from this condition. Please provide as much information as you can. If you are unsure whether something is relevant, put it down anyway, it may be helpful. If you are unsure about 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 |
|------------|----------------|----------------|------------|
| 1          |                |                |            |
| 2          |                |                |            |
| 3          |                |                |            |

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 2 and/or 3 that you suffer/have suffered from this condition. Please provide as much information as you can. If you are unsure whether something is relevant, put it down anyway, it may be helpful. If you are unsure about 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 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 (nasogastric tube/PEG tube in place)
- Needs some help (e.g. cutting food, spreading butter)
- 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 only to 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 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, 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 your consent to the Provider to apply for such a report if it is needed.

### 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 the Provider.

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

- The doctor can forward it to the Provider immediately, who 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 the Provider, 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, the Provider will notify you if one is applied for, 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 the Provider.
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, forms 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 Provider's behalf.

I/we understand that the Provider reserves the right to offer revised policy terms should the Provider 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/our rights under the relevant legislation, as detailed above, governing access to medical records.

I/we agree that the Provider may confirm the information I/we have supplied regarding my/our status as a smoker by way of a non-invasive test.

The Provider(s), which will be asked to provide a quotation on enhanced and impaired terms, will be selected from the open market. A list of potential Providers is shown below although this will change from time to time.

Aviva Canada Life Just Retirement Legal & General LV= MGM Advantage Partnership Prudential

The Provider(s) that receive this completed form, may use some of the information to advise you by post or telephone of other products and services offered by them 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         | <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"/>  |
| Telephone number      | <input type="text"/>  | <input type="text"/>  |
| Fax number            | <input type="text"/>  | <input type="text"/>  |
|                       | Annuitant   | Dependant   |
| Name (block capitals) | <input type="text"/>  | <input type="text"/>  |
| Signature             | <input type="text"/>  | <input type="text"/>  |
| Date                  | <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy) | <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy) |

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|                |                      |
|----------------|----------------------|
| Argentina      | Malaysia             |
| Australia      | Mexico               |
| Austria        | Netherlands          |
| Belgium        | New Zealand          |
| Brazil         | Norway               |
| Canada         | Philippines          |
| Chile          | Poland               |
| China          | Portugal             |
| Colombia       | Singapore            |
| Czech Republic | South Korea          |
| Denmark        | Spain                |
| Finland        | Sweden               |
| France         | Switzerland          |
| Germany        | Taiwan               |
| Hong Kong      | Thailand             |
| Hungary        | Turkey               |
| India          | United Arab Emirates |
| Indonesia      | United Kingdom       |
| Ireland        | United States        |
| Italy          | Venezuela            |
| Japan          |                      |

For further information, please contact your local Mercer office or visit our website at:

[www.mercer.com](http://www.mercer.com)