

MERCER



Medical Application Form



Consulting. Outsourcing. Investments.



Section One: Personal details

Your details

Title Mr Mrs Miss Ms Other
 If "other", please specify

Gender Male Female

Surname

Forename(s)

Date of birth / /
 D D M M Y Y Y Y

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 / /
 D D M M Y Y 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

Home address

Postcode

Daytime telephone number

Evening telephone number

Email address

Your dependant's details

Mr Mrs Miss Ms Other

Male Female

/ /
 D D M M Y Y Y Y

Single Married/Civil partnership
 Separated Divorced Widowed

Full time Part time

/ /
 D D M M Y Y Y Y

In own home – alone
 In own home – with someone else
 With relatives
 In a residential home
 In a care home

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

Section Two: Medical assessment form

Important notes

Please disclose as much information about your health as possible before signing this form. An annuity may commence on the basis of the medical information supplied. Failure to disclose material facts about your health may result in any annuity enhancement being reduced or removed in full. Material facts are those that an insurer would regard as likely to influence the assessment and acceptance of a proposal. If you are unsure whether certain facts for your case are material, they should be disclosed. 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.

Your details

Your dependant's details

Height

ft ins or cms

ft ins or cms

Weight

st lbs or kgs

st lbs or kgs

Waist measurement

ins

ins

Do you currently smoke?

Yes No

Yes No

Have you been a regular smoker for the last 10 years?

Yes No

Yes No

If you are a regular smoker, please indicate the average **daily** level

Manufactured cigarettes

Manufactured cigarettes

Cigars

Cigars

If you are a regular smoker, please indicate the average **weekly** level

Ozs rolling tobacco or

Ozs rolling tobacco or

Gms rolling tobacco

Gms rolling tobacco

Ozs/gms pipe tobacco

Ozs/gms pipe tobacco

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

___ ___ / ___ ___ to ___ ___ / ___ ___
M M Y Y to M M Y Y

___ ___ / ___ ___ to ___ ___ / ___ ___
M M Y Y to M M Y Y

How much **did** you smoke?

Manufactured cigarettes

Manufactured cigarettes

Ozs/gms rolling tobacco

Ozs/gms rolling tobacco

Cigars

Cigars

Pipe

Pipe

If you smoke but neither you nor your dependant has any other medical conditions, you need only to complete the Declaration and Consent on the last page of the form.

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.)

Have you been diagnosed with high blood pressure (hypertension)?

Yes No ___ ___ / ___ ___
M M Y Y

Yes No ___ ___ / ___ ___
M M Y Y

If yes, specify last reading(s)

Date of reading(s)

___ ___ / ___ ___ ___ ___ / ___ ___
M M Y Y M M Y Y

___ ___ / ___ ___ ___ ___ / ___ ___
M M Y Y M M Y Y

Heart attack, angina and other vascular conditions questionnaire

Annuitant:

Dependant:

Name:

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

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

Have you ever been diagnosed with any of the following?

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

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

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

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

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

Diabetes questionnaire

Annuitant:

Dependant:

Name:

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

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

When was your diabetes diagnosed?

Date: /
M M Y Y

What type of diabetes do you have?

Type 1 Type 2

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:

/
M M Y Y

Have you been diagnosed with any of the following diabetic complications?

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

If yes, please give details:

Please give the last two readings for HbA1c:

Reading 1

Date: /
M M Y Y

Reading 2

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

How often do you monitor your own blood glucose levels?

Please provide any further information you think may be important:

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

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.

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 of the tumour, for example, TNM or Duke classification?

Yes

No

If yes, please give details:

Do you know the grading of the tumour?

Yes

No

If yes, please give details:

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

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

Only local tumour growth

Tumour invaded adjacent lymph nodes

Tumour invaded distant lymph nodes

If yes, please advise number of nodes affected and location:

Tumour spread to distant organs (distant metastases).

If so, where:

In the case of prostate cancer, please advise where known:

Current Prostate Specific Antigen (PSA) level:

Date recorded:

___ / ___ / ___
M M Y Y

Pre-treatment PSA level:

Date:

___ / ___ / ___
M M Y Y

Gleason Score:

Date recorded:

___ / ___ / ___
M M Y Y

Stroke questionnaire

Annuitant:

Dependant:

Name:

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

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)

Subarachnoid Haemorrhage (SAH)

Cerebral haemorrhage/bleed

TIA (Transient Ischaemic Attack – mini-stroke)

Please advise of any of the following ongoing problems:

Speech difficulties

Vision impairment

Paralysis arm

Paralysis leg

Short-term memory loss

What medication are you currently taking?

Medication	Dose/frequency	Date commenced	Date ended

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:

Please also complete the Activities of Daily Living questionnaire on page 13

Respiratory/lung disease questionnaire

Annuitant:

Dependant:

Name:

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

Have you ever been diagnosed with any of the following?

- Chronic obstructive airways/pulmonary disease (COAD/COPD)
- Emphysema
- Bronchiectasis
- Pneumoconiosis
- Asbestosis
- Asthma
- Pleural plaques
- Sleep apnoea
- Other

Please specify:

When was your condition diagnosed?

___ / ___
M M Y Y

Is your lung function?

- Minimally impaired (FEV1 >70%) Yes No
- Moderately impaired (FEV1 50%–70%) Yes No
- Severely impaired (FEV1 <50%) Yes No

Do any of the following also apply:

	Never	Some of the time	Most of the time	Always
<input type="checkbox"/> Chest infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Need for home oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Need for a continuous positive airway pressure (CPAP) breathing machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Signs of cor pulmonale (right heart failure due to lung disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breathlessness walking from room to room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breathlessness climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breathlessness when lying flat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Taking oral steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been admitted to hospital? Never Once More than once

Last admission ___ / ___
M M Y Y

What medication are you currently taking?

Medication	Dose/frequency	Date commenced	Date ended

Please provide any further information you think may be important:

Other neurological condition questionnaire

Annuitant:

Dependant:

Name:

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

Have you ever been diagnosed with any of the following?

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

Please specify:

Have you been admitted to hospital?

- Never Once More than once

Last admission ___ ___ / ___ ___
M M Y Y

When was your condition diagnosed?

___ ___ / ___ ___
M M Y Y

Have you had any of the following symptoms?

- Pressure sores Yes No
- Falls Yes No
- Tremors Yes No
- Seizures Yes No

What medication are you currently taking?

Medication	Dose/frequency	Date commenced	Date ended

Please advise last Mini-Mental State Examination (MMSE) score if known:

Please provide any further information you think may be important:

Please also complete the Activities of Daily Living questionnaire on page 13

Activities of Daily Living (ADL) questionnaire

Annuitant:

Dependant:

Name:

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

Please advise relevant diagnosis:

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

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 use – permanent
- Wheelchair use – non-permanent
- Walks with assistance (frame/stick, etc.)
- Independent (needs no assistance)

Transferring:

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

Please advise any progression in the last five years:

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

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
- Needs some assistance
- Independent

Feeding:

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

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.

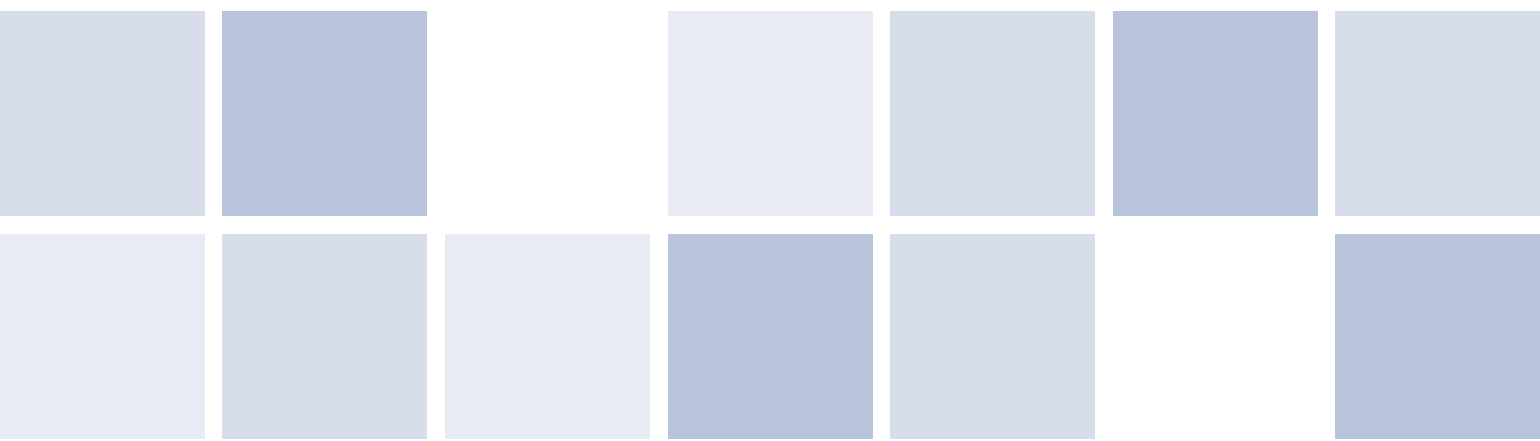
Your data will be processed fairly and securely in accordance with the Data Protection Act 1998. Details of your rights under the Act, the data which the Provider holds, the data which may be passed to organisations outside of the Provider and the organisations which might be involved, can be obtained 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 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 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 indicate 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 amend any part of a report you consider incorrect or misleading, and you 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 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 rights under the relevant legislation as detailed overleaf 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.

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

The Provider(s) that receive(s) 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 — 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 style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Address	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Telephone number	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Fax number	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Name (block capitals)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Signature	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Date	___ / ___ / ___ ___ D D M M Y Y Y Y	___ / ___ / ___ ___ D D M M Y Y Y Y



Quick checklist

Have you and your dependant (if applicable) ...

- Completed pages one, two and three of the form?
- Have you looked at Table A on page three and completed any questionnaires that are required?
- Have you completed the Activities of Daily Living (ADL) questionnaire on page 13 if required?
- Have you read pages 15 and 16 and indicated whether you wish to see a doctor's report?
- Have you signed and dated the form on page 16 and completed your doctor's details?

Please now return the form, together with any other paperwork, to your pensions administrator or your usual contact.

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

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