



## Enhanced Pension Annuity Quotation Request Form

**Annuitant/Dependant** to complete sections **one** and **two**

**Financial Adviser** to complete sections **three** and **four**

### **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.

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

# NORTH WALES INDEPENDENT ADVICE

Quote Reference No. (if applicable)

Source of quote

## 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

\_\_ / \_\_ / \_\_\_\_

\_\_ / \_\_ / \_\_\_\_

National Insurance number

\_\_ | \_\_ | \_\_ | \_\_ | \_\_

\_\_ | \_\_ | \_\_ | \_\_ | \_\_

Nationality

Marital Status

Single  Married/Civil Partnership   
Separated  Divorced  Widowed

Single  Married/Civil Partnership   
Separated  Divorced  Widowed

Relationship to the dependant

Present occupation

Full-time  Part-time

Full-time  Part-time

If no longer working,  
previous occupation

Date ceased

\_\_ / \_\_ / \_\_\_\_

\_\_ / \_\_ / \_\_\_\_

Are you living

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

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

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**

# NORTH WALES INDEPENDENT ADVICE

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

### 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

If yes, please advise year started

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  
 Cigars

Manufactured cigarettes  
 Cigars

If you are a regular smoker, please indicate the average **weekly** level  
 Ozs rolling tobacco **or**  
 Gms rolling tobacco  
 Ozs/gms pipe tobacco

Ozs rolling tobacco **or**  
 Gms rolling tobacco  
 Ozs/gms pipe tobacco

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

/   to   /

How much **did** you smoke:  
 Manufactured cigarettes  
 Ozs/gms rolling tobacco  
 Cigars  
 Pipe

Manufactured cigarettes  
 Ozs/gms rolling tobacco  
 Cigars  
 Pipe

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   /

Yes  No   /

If yes, specify last reading(s)

Date of reading(s)   /     /

/     /

Number and name(s) of medication(s) prescribed (excluding aspirin)

Have you been diagnosed with high cholesterol  Yes  No   /

Yes  No   /

If yes, specify last reading(s)

Date of reading(s)   /     /

/    /

Number and name(s) of medication(s) prescribed

# NORTH WALES INDEPENDENT ADVICE

## 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.

**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

Condition 1



Condition 2



Condition 3



For any conditions showing in Table A at the bottom of the page, please complete the relevant questionnaire(s). For any other conditions, please complete the questions below (and, if relevant, the Activities of Daily Living questionnaire on page 13).

	<i>Condition 1</i>	<i>Condition 2</i>	<i>Condition 3</i>	<i>Condition 1</i>	<i>Condition 2</i>	<i>Condition 3</i>
When were you first diagnosed with this condition?	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y
When did you last suffer symptoms for this condition?	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y
When did you last receive medication /treatment for this condition?	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y
When were you last admitted to hospital for this condition?	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y	__ __ / __ __ M M / Y Y

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Have you received any of the following treatments within the past 5 years? Please tick box.

None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify



Your current medication	Dose prescribed	Frequency
1		
2		
3		

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

## TABLE A

If you have ever suffered with any of the following please complete the relevant questionnaire(s).

Heart condition .....	page 4
Diabetes .....	page 6
Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour .....	page 7
Stroke – please also complete the ADL questionnaire .....	pages 9 & 13
Respiratory/lung disease .....	page 10
Multiple sclerosis – please also complete the ADL questionnaire .....	pages 11 & 13
Neurological disease – please also complete the ADL questionnaire .....	pages 12 & 13

## 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) <input type="checkbox"/>	How many arteries <input style="width: 40px;" type="text"/>	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Coronary angioplasty/stents <input type="checkbox"/>	Number of arteries treated <input style="width: 40px;" type="text"/>	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Aortic valve replacement <input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Mitral valve replacement <input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Tricuspid valve replacement <input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Pacemaker <input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Cardioversion/ablation <input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$
Aortic aneurysm repair <input type="checkbox"/>	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$

# NORTH WALES INDEPENDENT ADVICE

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

Last admission   /  /  

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

Please advise date and result of any stress (exercise) ECG testing eg. using a bicycle or treadmill.

Please provide any further information you think may be important.

# 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:  $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$

Is your diabetes?

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:

$\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$

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:  $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$

Reading 2

Date:  $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$

Have you ever been admitted into hospital as a result of your diabetes?  Yes  No If yes, when?  $\frac{\text{M}}{\text{M}} / \frac{\text{Y}}{\text{Y}}$

How often do you monitor your own blood glucose levels?

Please provide any further information you think may be important.

## Cancer, leukaemia, lymphoma, 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:  /  /

Pre-treatment PSA level:

Date:  /  /

Gleason Score:

Date recorded:  /  /

# NORTH WALES INDEPENDENT ADVICE

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

Surgery

Type of surgery:

Date:  /  /  -

Chemotherapy Date commenced:  /  /  -  Date ended:  /  /  -

Radiotherapy (including brachytherapy) Date commenced:  /  /  -  Date ended:  /  /  -

Bone marrow/stem cell transplant Date commenced:  /  /  -  Date ended:  /  /  -

Hormone therapy Date commenced:  /  /  -  Date ended:  /  /  -

Other  (Please give full details)

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

What medication are you currently taking?

Medication	Dose/frequency	Date commenced	Date ended

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.

## 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)

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

**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
Chest infections	<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"/>
Need for a continuous positive airway pressure (CPAP) breathing machine	<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"/>
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"/>
Breathlessness when lying flat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.

## Multiple sclerosis questionnaire

Annuitant:

Dependant:

Name:

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

When was your multiple sclerosis diagnosed?

\_ M \_ M / \_ Y \_ Y

**Please advise subtype, if known:**

Relapsing remitting     Secondary progressive     Primary progressive     Progressive relapsing

Please advise number of attacks in the last 5 years:

**What medication are you currently taking?**

Medication	Dose/frequency	Date commenced	Date ended

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

Last admission    \_ M \_ M / \_ Y \_ Y

**Do you have or have you had any of the following:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Bladder incontinence/self-catheterisation                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Secondary infection (eg. pneumonia)                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Progressive mental deterioration                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Impairment of vision                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Impairment of speech                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Paralysis of a limb  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of steroids (eg. prednisolone) on more than 1 occasion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Please provide any further information you think may be important.**

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

## 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Falls          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tremors        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**What medication are you currently taking?**

Medication	Dose/frequency	Date commenced	Date ended

Please advise last 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.)

### Bowels:

- Incontinent (or requires enema)
- Occasional accident (once a week)
- Continent

### 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)

### Bathing:

- Dependent
- Needs some assistance
- Independent

### Transferring:

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

### Feeding:

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

### Bladder:

- Incontinent/catheterised/unable to manage alone
- Occasional accident (once a week)
- Continent

Please advise any progression in the last 5 years:

- Stable (no/minimal change)
- Deteriorating (impact to 2 or more ADLs above/acute episodes)
- Rapid deterioration

## 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:**

- |                                      |  |  |                                |  |
|--------------------------------------|--|--|--------------------------------|--|
| <input type="checkbox"/> Canada Life | <input type="checkbox"/> Just Retirement | <input type="checkbox"/> Legal & General | <input type="checkbox"/> Aviva | <input type="checkbox"/> MGM Advantage |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Prudential      | <input type="checkbox"/> LV=             |                                |  |

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.

	<b>ANNUITANT</b>	<b>DEPENDANT</b>
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"/>
	<b>ANNUITANT</b>	<b>DEPENDANT</b>
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"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

## 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    /    /    /    /    /    /    /   

**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	<input type="text" value="£"/>	<input type="text" value=""/> %	<input type="text" value=""/> %
Post 05/04/1988	<input type="text" value="£"/>	<input type="text" value=""/> %	<input type="text" value=""/> %

**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=)*  Yes  No

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

Would you like an enhanced Income Choice Annuity quotation? *(only offered by Prudential)*  
*(Both Minimum Starting income level and Maximum Starting income level will be supplied)*  Yes  No

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:**