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.

Annuitant/Dependant to complete sections 1, 2 and 3.
Financial Advisor to complete sections 4 and 5.

Table of Contents

Section 1: Personal Details

Mandatory *

Life basis: ☐ Single life ☐ Joint life

Reference*:

	Annuitant	Dependant
Title:		
Forename(s)*:		
Surname*:		
Date of birth*:	(dd/mm/yyyy)	(dd/mm/yyyy)
Age:		
Sex*:	☐ Male ☐ Female	☐ Male ☐ Female
Postcode*:		
Marital status*	☐ Single	☐ Single
	☐ Married	☐ Married
	☐ Civil partnership	☐ Civil partnership
	☐ Cohabiting	☐ Cohabiting
	☐ Intend to marry	☐ Intend to marry
	☐ Intend to form civil partnership	☐ Intend to form civil partnership
	☐ Divorced	☐ Divorced
	☐ Dissolved civil partnership	☐ Dissolved civil partnership
	☐ Separated	☐ Separated
	☐ Separated civil partnership	☐ Separated civil partnership
	☐ Widowed	☐ Widowed
	☐ Surviving civil partnership	☐ Surviving civil partnership

Personal details questionnaire continued…

	Annuitant	Dependant
Relationship to the dependant:		
Any health issues*:	☐ Yes ☐ No	☐ Yes ☐ No
Residential status*:	☐ 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
Current or last Occupation*:		
Employment status*:	☐ Retired ☐ Full-time ☐ Part-time	☐ Retired ☐ Full-time ☐ Part-time
Date ceased Employment*:	(mm/yyyy)	(mm/yyyy)

Does the client and dependant (if applicable) consent to the providers sharing their personal and medical information with one another for the purpose of obtaining a market leading comparison quote (in accordance with FCA regulations). *: ☐ Yes ☐ No

Section 2: Annuitant/Dependant Health

Medical condition - Lifestyle questionnaire

Mandatory *

	Annuitant	Dependant
Currently Smoking*:	☐ Yes ☐ No	☐ Yes ☐ No
Previously smoking history:	☐ Never/Occasional ☐ Previous regular smoker	☐ Never/Occasional ☐ Previous regular smoker
Regular daily smoker for 10 years or more:	☐ Yes ☐ No	☐ Yes ☐ No
Manufactured cigarettes per day:		
Cigars/day:		
Cigar size:	☐ Mini (less than 3.3g) ☐ Regular (3.3g-6.5g) ☐ Large (more than 6.5g)	☐ Mini (less than 3.3g) ☐ Regular (3.3g-6.5g) ☐ Large (more than 6.5g)
Rolling tobacco/day:	grams/ounces	grams/ounces
Pipe tobacco/week:	grams/ounces	grams/ounces
Date started:	(mm/yyyy)	(mm/yyyy)
Date stopped:	(mm/yyyy)	(mm/yyyy)
Alcohol consumption:	Unit(s) per week	Unit(s) per week
Height*:	metric/imperial	metric/imperial
Weight*:	metric/imperial	metric/imperial
Waist measurement:	metric/imperial	metric/imperial

Medical condition – Cancer questionnaire

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

Please complete a separate questionnaire If you have a history of more than one different type of cancer (maximum 5).

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Name of tumour/malignant*:

Location of tumour*:

Date of first diagnosis*: (mm/yyyy)

General classification*: ☐ Benign ☐ Pre-Cancerous ☐ Malignant

Grading*: ☐ Grade 1 (low Grade) ☐ Grade 3 (high Grade)
☐ Grade 2 (intermediate Grade) ☐ Unknown

Staging type*:

Stage*: ☐ Stage 0 ☐ Stage 3
☐ Stage 1 ☐ Stage 4
☐ Stage 2

Substage/subtype*: ☐ A ☐ B ☐ C

Best description of nature Of tumour*:
☐ Carcinoma-in-situ
☐ Only local tumour growth
☐ Tumour invaded adjacent lymph nodes
☐ Tumour invaded distant lymph nodes
☐ Tumour spread to distant organs (distant metastases)

Number of nodes affected:

Locations of nodes/organs:

Medical condition – Cancer questionnaire continued…

In case of prostate cancer, please advise where known:

		Date (mm/yyyy)
Current prostate specific antigen (PSA) level:		
Pre-treatment prostate specific antigen (PSA) level:		
Gleason score (Single score):		
OR		
Gleason score (Double score – First score):		
(Double score – Second Score):		

Treatments:		**Date commenced*** (mm/yyyy)	**Date ended (leave blank if ongoing)** (mm/yyyy)
Surgery:	☒		
Chemotherapy:	☒		
Radiotherapy (including brachytherapy):	☒		
Bone marrow/stem cell transplant:	☒		
Hormone therapy:	☒		
Other (e.g. BCG, HIFU, Immunotherapy):	☒		

Recurrence in the same location: ☐ Yes ☐ No Date*: (mm/yyyy)

Date of last consultation, if known: (mm/yyyy)

Fully discharged: ☐ Yes ☐ No

Medical condition – Cancer questionnaire continued…

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Diabetes questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Date of first diagnosis*:

Type*: ☐ Type 1 ☐ Type 2 ☐ Not known

Method of control: ☐ Diet only ☐ Non-insulin (tablet / injection) ☐ Insulin

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Previous medications (for this condition) if changed:

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Diabetes questionnaire continued…

Complications*:

Heart disease: ☐ Yes ☐ No

Retinopathy (excluding eye disease): ☐ Yes ☐ No

Neuropathy: ☐ Yes ☐ No

Kidney disease (protein in urine): ☐ Yes ☐ No

Peripheral vascular disease (ulceration): ☐ Yes ☐ No

Amputation: ☐ Yes ☐ No

Poor circulation: ☐ Yes ☐ No

Most recent HbA1c readings (not blood glucose):

			Date (mm/yyyy)
Reading 1:		DCCT(%) / IFFC (mmol/mol)	
Reading 2:		DCCT(%) / IFFC (mmol/mol)	

Hospital admissions:

Admitted to hospital as a result of diabetes: ☐ Yes ☐ No

Date of last admission: ☐ (mm/yyyy)

Frequency blood glucose monitored:

Number of times monitored: ☐ Time period: ☐

Medical condition – Heart questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Heart conditions*:		**Date of first Diagnosis** (mm/yyyy)	**No. of occurrences**	**Ongoing**	
Heart attack:	☒			☐ Yes	☐ No
Angina:	☒			☐ Yes	☐ No
Heart failure:	☒			☐ Yes	☐ No
Aortic aneurysm:	☒			☐ Yes	☐ No
Cardiomyopathy:	☒			☐ Yes	☐ No
Heart valve disorders:	☒			☐ Yes	☐ No
Atrial fibrillation (AF):	☒			☐ Yes	☐ No
Other irregular heart rhythm:	☒			☐ Yes	☐ No
Other: Condition name:	☒			☐ Yes	☐ No

Symptoms of heart conditions:	**Never**	**Some of the time**	**Most of the time**	**Always**
Symptoms at rest:	☐	☐	☐	☐
Breathlessness walking from room to room:	☐	☐	☐	☐
Breathlessness climbing stairs:	☐	☐	☐	☐
Chest pains on minor to moderate activity:	☐	☐	☐	☐
Chest pains on severe exertion only:	☐	☐	☐	☐
Swollen ankles:	☐	☐	☐	☐
Episode of dizziness:	☐	☐	☐	☐
Episode of blackouts:	☐	☐	☐	☐

Medical condition – Heart questionnaire continued…

Current medication (for this condition)

Name of heart condition*	Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started*

Medical condition – Heart questionnaire continued…

Arterial surgery:		**No. of arteries***	**Date of most recent procedure*** (mm/yyyy)
Coronary artery bypass graft:	☒		
Coronary angioplasty/stents:	☒		

Non-arterial surgery:		**Successful***		**Date of most recent procedure*** (mm/yyyy)
Aortic valve replacement:	☒	Yes	No	
Mitral valve replacement:	☒	Yes	No	
Tricuspid valve replacement:	☒	Yes	No	
Pacemaker:	☒	Yes	No	
Cardioversion/ablation:	☒	Yes	No	
Aortic aneurysm repair:	☒	Yes	No	

			Date of last consultation (mm/yyyy)
Currently under cardiologist:	Yes	No	

Future treatment planned: Yes No

If yes, future treatment type*:

Date of last stress ECG test: (mm/yyyy)

Number of times admitted to hospital (for this condition) in last 10 years:

Date of last admission: (mm/yyyy)

Medical condition – High cholesterol questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Date of first diagnosis:

Last two readings and dates (Total cholesterol)

Most recent HbA1c readings (not blood glucose):

	Total (mmol/l)	**LDL** (mmol/l)	**HDL** (mmol/l)	**Date** (mm/yyyy)
Reading 1:				
Reading 2:				

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Hypertension (high blood pressure)

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Date of first diagnosis: (mm/yyyy)

Last two readings and dates:

	Systolic		Diastolic	Date (mm/yyyy)
Reading 1:		/		
Reading 2:		/		

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Multiple sclerosis questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Date of first diagnosis*: (mm/yyyy)

Subtype*: ☐ Relapsing remitting ☐ Secondary progressive

☐ Primary progressive ☐ Progressive relapsing ☐ Not known

Number of attacks in the last 5 years:

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Multiple sclerosis questionnaire continued…

Number of times admitted to hospital (for this condition): ☐ Date of last admission: ☐ (mm/yyyy)

Impact of condition:

Bladder incontinence/self-catheterisation*:	☐ Yes	☐ No
Secondary infection (for example pneumonia)*:	☐ Yes	☐ No
Progressive mental deterioration*:	☐ Yes	☐ No
Impairment of vision*:	☐ Yes	☐ No
Impairment of speech*:	☐ Yes	☐ No
Paralysis of a limb*:	☐ Yes	☐ No
Use of steroids (e.g. prednisolone) on more than 1 occasion*:	☐ Yes	☐ No

Medical condition – Neurological questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Neurological disease conditions*:		**Date of first diagnosis** (mm/yyyy)
Senile dementia:	☒	
Vascular dementia:	☒	
Alzheimer's disease:	☒	
Parkinson's disease:	☒	
Motor neurone disease:	☒	
Other:		

Number of times admitted to hospital (for this condition): ☐ Date of last admission: (mm/yyyy)

Impact of condition:

Pressure sores:	☐	Yes	☐	No
Falls:	☐	Yes	☐	No
Tremors:	☐	Yes	☐	No
Seizures:	☐	Yes	☐	No

MMSE score (out of 30): ☐

Medical condition – Neurological questionnaire continued…

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Respiratory questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Respiratory/Lung disease conditions*:		**Date of first diagnosis** (mm/yyyy)
Chronic obstructive airways/ pulmonary disease (COAD/COPD):	☐	
Emphysema:	☐	
Bronchiectasis:	☐	
Pneumoconiosis (a type of lung disease related to occupation):	☐	
Asbestosis disease:	☐	
Asthma:	☐	
Pleural plaques:	☐	
Sleep apnoea:	☐	
Other:		

Lung function*:

☐ Minimally impaired (FEV1>70%) or no known effect

☐ Moderately impaired (FEV1 50-70%)

☐ Severely impaired (FEV1<50%)

Medical condition – Respiratory questionnaire continued…

Impact of conditions (ongoing):

Do any of the following apply due to the respiratory/lung condition?

	Never	Some of the time	Most of the time	Always
Chest infection:	☐	☐	☐	☐
Need for home oxygen:	☐	☐	☐	☐
Need for a continuous positive airway Pressure (CPAP) breathing machine:	☐	☐	☐	☐
Signs of cor pulmonale (right heart failure due to lung disease):	☐	☐	☐	☐
Breathlessness walking from room to room:	☐	☐	☐	☐
Breathlessness climbing stairs:	☐	☐	☐	☐
Breathlessness when lying flat:	☐	☐	☐	☐
Oral steroid in tablet form e.g. Prednisolone:	☐	☐	☐	☐

Number of times admitted to hospital (for this condition): ☐ Date of last admission: ☐ (mm/yyyy)

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started*

Medical condition – Stroke questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Episode/Type*: ☐ Cerebrovascular accident - major stroke (CVA)
☐ Transient Ischaemic Attack - mini stroke (TIA)
☐ Subarachnoid Haemorrhage (SAH)
☐ Cerebral Haemorrhage/Bleed

Date of first diagnosis*: (mm/yyyy)

Body part most affected:

Duration of initial symptoms:

Fully recovered: ☐ Yes ☐ No

Duration taken until recovery made*:

Episode/Type*: ☐ Cerebrovascular accident - major stroke (CVA)
☐ Transient Ischaemic Attack - mini stroke (TIA)
☐ Subarachnoid Haemorrhage (SAH)
☐ Cerebral Haemorrhage/Bleed

Date of first diagnosis*: (mm/yyyy)

Body part most affected:

Duration of initial symptoms:

Fully recovered: ☐ Yes ☐ No

Duration taken until recovery made:

Medical condition – Stroke questionnaire continued…

Episode/Type*:	☐	Cerebrovascular accident - major stroke (CVA)
	☐	Transient Ischaemic Attack - mini stroke (TIA)
	☐	Subarachnoid Haemorrhage (SAH)
	☐	Cerebral Haemorrhage/Bleed
Date of first diagnosis*:		(mm/yyyy)
Body part most affected:		
Duration of initial symptoms:		
Fully recovered:	☐ Yes	☐ No
Duration taken until recovery made:		

Episode/Type*:	☐	Cerebrovascular accident - major stroke (CVA)
	☐	Transient Ischaemic Attack - mini stroke (TIA)
	☐	Subarachnoid Haemorrhage (SAH)
	☐	Cerebral Haemorrhage/Bleed
Date of first diagnosis*:		(mm/yyyy)
Body part most affected:		
Duration of initial symptoms:		
Fully recovered:	☐ Yes	☐ No
Duration taken until recovery made:		

Medical condition – Stroke questionnaire continued…

Ongoing symptoms:

Please enter current and ongoing symptoms as a result of stroke(s).

Speech difficulties:	☐	Yes	☐	No
Vision impairment:	☐	Yes	☐	No
Paralysis of arm:	☐	Yes	☐	No
Paralysis of leg:	☐	Yes	☐	No
Short term memory loss:	☐	Yes	☐	No

Current status: ☐ Fully discharged ☐ Under follow up

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Any other conditions questionnaire

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

For multiple other conditions, please complete a separate questionnaire (maximum 5).

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Condition name*:

Date of first diagnosis*: (mm/yyyy)

Date symptoms last suffered*: (mm/yyyy)

Date of last medication/treatment: (mm/yyyy)

Renal dialysis in last five years*: ☐ Yes ☐ No

Surgery in last five years*: ☐ Yes ☐ No

Other treatments in last five years:* ☐ Yes ☐ No

Number of times admitted to hospital (for this condition): ☐ Date of last admission: (mm/yyyy)

Medical condition – Any other conditions questionnaire continued…

Current medication (for this condition)

Medication name*	Dose*	Dose unit*	No. of doses*	Frequency*	Date started

Medical condition – Additional information

Section 3 – Activity of daily living (ADL) questionnaire

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

Annuitant: ☐ Dependant: ☐

Name:

Mandatory *

Please enter all medical conditions **from section 2** which have led to any reduction in the ability to carry out these activities:

Dressing*:

☐ Independent (including buttons, zips, laces etc.)

☐ Needs help, but can do about half unaided

☐ Dependent, requires full assistance

Condition(s):

Bowels*:

☐ Continent

☐ Occasional accident (once a week)

☐ Incontinent (or requires enema)

Condition(s):

Activity of daily living (ADL) questionnaire continued…

Mobility*:

- ☐ Independent (needs no assistance)
- ☐ Walks with assistance (frame/stick etc.)
- ☐ Wheelchair use – non-permanent
- ☐ Wheelchair use – permanent
- ☐ In need of daily nursing care
- ☐ Bedridden

Condition(s):

Bathing*:

- ☐ Independent
- ☐ Needs some assistant
- ☐ Dependant

Condition(s):

Transferring*:

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

Condition(s):

Activity of daily living (ADL) questionnaire continued…

Feeding*:

☐ Independent

☐ Needs some help cutting, spreading butter, etc.

☐ Unable, (naso-gastric tube/PEG in place)

Condition(s):

Bladder*:

☐ Continent

☐ Occasional accident (once a week)

☐ Incontinent/catheterised/unable to manage alone

Condition(s):

Progression in the last 5 years*:

☐ Stable (no/minimal change)

☐ Deteriorating (impact to 2 or more ADLs above/acute episode)

☐ Rapid deterioration

Condition(s):

Section 4 - Contract basis questionnaire

Mandatory *

Total purchase amount (Fund)*:

Fund source/type of scheme*:

Transfer or Open market option*: Transfer OMO

If Transfer, PCLS/Tax free cash required*: Maximum

Nil

Specified PCLS/TFC: Generally limited to 25% of Fund

Entitlement to PCLS/Tax free cash greater than 25%?*: Yes No

Do you have any additional pension benefits?*: Yes No

Guaranteed Annual Income *: GAR GMP Section 9(2B) Rights

Guaranteed Annuity Rate (£)*:

Payable (DD/MM/CCYY)*: Specified date **OR** from age

Guaranteed Minimum Pension (£)*:

Payable (DD/MM/CCYY)*: Specified date **OR** from age

Section 9(2B)Rights (£)*:

Payable (DD/MM/CCYY)*: Specified date **OR** from age

Contract type*: Guaranteed Investment linked

Annuity term*: For life Fixed term

Fixed term*: Years Months **OR** To age

Fixed term income options*: Provider calculated

Minimum/Nil

Maximum

Amount:

Section 4 - Contract basis questionnaire continued…

Investment linked quote basis*:	☐ Assumed bonus/growth rate ☐ Required annual income
Assumed bonus/growth rate*:	☐ %
Investment linked income*:	☐ Minimum ☐ Maximum ☐ Amount:
Escalation*:	☐ Level ☐ RPI ☐ LPI ☐ Fixed
Escalation %*:	☐ %
Guaranteed period:	☐ Years
Value protection*:	☐ %
Value protection payment basis*:	☐ On annuitant death ☐ On second death
Commencement date*:	☐ Today ☐ Specific date: (dd/mm/yyyy)
Payment frequency*:	☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Yearly
In advance or in arrears*:	☐ In advance ☐ In arrears
If in arrears, with proportion*:	☐ Yes ☐ No
Dependant's %*:	☐ %
Any spouse*:	☐ Yes ☐ No
Overlap*:	☐ Yes ☐ No

Section 5 - Remuneration questionnaire

Mandatory *

Advice type: ☐ Advised ☐ Non advised

Basis of sale (Advised): ☐ Independent ☐ Restricted ☐ Simplified

Basis of sale (Non advised): ☐ Execution only ☐ No advice ☐ Direct offer ☐ Not known

Remuneration basis: ☐ Adviser charge ☐ Commission

Non-advised only

Commission remuneration basis only:

Commission: ☐ Standard terms

☐ Standard % or amount: ☐ % **OR** £ ☐

☐ Nil commission

Section 3 - Remuneration questionnaire continued…

Adviser charge facilitated by provider: ☐ Yes ☐ No

If adviser charge facilitated by provider:	
Initial adviser charge:	☐ % **OR** £ ☐
Ongoing adviser charge: Percentage of fund value per annum (**%**) ☐ Frequency: ☐ Monthly ☐ Quarterly ☐ Annually Start date: ☐ (dd/mm/yyyy) Duration: ☐ Length of plan ☐ Specified period ☐ ☐ (Months or Years	
Fixed amount per payment (**£**): ☐ Frequency: ☐ Monthly ☐ Quarterly ☐ Annually Start date: ☐ (dd/mm/yyyy) Duration: ☐ Length of Plan ☐ Specified period ☐ ☐ (Months or Years)	
Fixed amount indexation: ☐ Level ☐ RPI ☐ AWEI ☐ Fixed: ☐ %	

*****END*****