

THE RETIREMENT ADVISER

A Division of LEBC Group



Enhanced Annuity Quotation Information Form

The completion of this medical form will allow The Retirement Adviser to investigate the possibility for you and/or your spouse for an enhanced or impaired life annuity. Any enhancement to the annuity rate quoted will improve your income for life. Please provide as much information as possible as this will help the underwriters make a decision on the rate quoted.

If you have any problems, or require any assistance, completing this form please call your allocated Consultant on their direct line. Alternatively, please call our helpline on 0808 1787 335.

Once completed, please return to:

The Retirement Adviser
Atlantic House
Imperial Way
Reading
Berkshire
RG2 0TD.

*“Is it time for a
quiet conversation?”[®]*

Medical Details – Applicant 1 (Annuitant)

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

Name:		
Date of Birth (DD/MM/YY):		Address:
Are you Male or Female:		
Height (ft/ins or cms):		
Weight (st/lbs or kgs):		
Occupation prior to retirement:		Postcode:

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

1. If you drink alcohol please state approximate intake per week units
 (1 pint of beer = 2 units 1 glass of wine = 1 unit 1 measure of spirits = 1 unit)

2. Are you currently a smoker and have been for the last 10 years Yes No

3. If no, have you ever been a smoker? Yes No

When did you stop, please give reasons why in box below.

4. If yes, please advise the average number of:

- a) Manufactured cigarettes you smoke per day? _____
- b) Cigars OR ounces/grams of pipe tobacco you smoke per week? _____
- c) Ounces/grams of cigarette tobacco you smoke per week? _____

5. If you suffer from high blood pressure please advise:

- a) BP readings POST medication if known (systolic/diastolic) _____
- b) Names of prescribed medications taken for high blood pressure? _____

6. If you suffer from high cholesterol please advise:

- a) Cholesterol level POST medication (mmol/l) if known _____
- b) Names of prescribed medications taken for high cholesterol? _____

7. Have you suffered from any of the following:

- | | No | *Yes |
|--|--------------------------|--------------------------|
| a) Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Heart Bypass or Angioplasty (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Diabetes (diet, tablet or insulin) (please specify medication and Hba1C reading if known) | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Asthma or Chronic Respiratory Disease (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Impaired Kidney or Ongoing Dialysis (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Bladder or Liver complaint (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Digestive or Bowel complaint (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Multiple Sclerosis (please specify incomplete paralysis or wheelchair-bound) | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Alzheimer's or Parkinson's disease | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Are you on a waiting list for treatment or awaiting test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| n) Any other serious illness or condition? | <input type="checkbox"/> | <input type="checkbox"/> |

* If yes, please give full details including: **date of diagnosis, treatment received (with dates), dates of hospitalisation & details of current medication being taken.**
 Please include a separate sheet if required.
 The more fully you answer the questions, the more accurate the assessment will be of your eligibility for enhanced rates.

Medical Details – Applicant 2 (Dependant)

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

Name:		
Date of Birth (DD/MM/YY):		Address:
Are you Male or Female:		
Height (ft/ins or cms):		
Weight (st/lbs or kgs):		
Occupation prior to retirement:		Postcode:

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

1. If you drink alcohol please state approximate intake per week

(1 pint of beer = 2 units 1 glass of wine = 1 unit 1 measure of spirits = 1 unit)

units

2. Are you currently a smoker and have been for the last 10 years

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

3. If no, have you ever been a smoker?

When did you stop, please give reasons why in box below.

4. If yes, please advise the average number of:

- a) Manufactured cigarettes you smoke per day? _____
- b) Cigars OR ounces/grams of pipe tobacco you smoke per week? _____
- c) Ounces/grams of cigarette tobacco you smoke per week? _____

5. If you suffer from high blood pressure please advise:

- a) BP readings POST medication if known (systolic/diastolic) _____
- b) Names of prescribed medications taken for high blood pressure? _____

6. If you suffer from high cholesterol please advise:

- a) Cholesterol level POST medication (mmol/l) if known _____
- b) Names of prescribed medications taken for high cholesterol? _____

7. Have you suffered from any of the following:

- | | No | *Yes |
|--|--------------------------|--------------------------|
| a) Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Heart Bypass or Angioplasty (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Diabetes (diet, tablet or insulin) (please specify medication and Hba1C reading if known) | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Asthma or Chronic Respiratory Disease (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Impaired Kidney or Ongoing Dialysis (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Bladder or Liver complaint (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Digestive or Bowel complaint (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Multiple Sclerosis (please specify incomplete paralysis or wheelchair-bound) | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Alzheimer's or Parkinson's disease | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Are you on a waiting list for treatment or awaiting test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| n) Any other serious illness or condition? | <input type="checkbox"/> | <input type="checkbox"/> |

* If yes, please give full details including: **dates of diagnosis, treatment received (with dates), dates of hospitalisation & details of current medication being taken.**
Please include a separate sheet if required.
The more fully you answer the questions, the more accurate the assessment will be of your eligibility for enhanced rates.

Applicant 1

Applicant 2

Condition 1

Date of Diagnosis _____

Date of Diagnosis _____

Condition 2

Date of Diagnosis _____

Date of Diagnosis _____

Condition 3

Date of Diagnosis _____

Date of Diagnosis _____

1. When did you last suffer symptoms or receive treatment for this condition? (please tick box)

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) 0-6 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) 7-24 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) 25 – 60 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) More than 60 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How long have you suffered from this condition? (please tick box)

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) 0 – 12 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) 13 – 60 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) 61 – 120 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) More than 120 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. When were you last hospitalised for this condition? (please tick box)

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) 0-12 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) 13 – 60 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) More than 60 months ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. What treatment have you received for this condition? (please tick box)

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) 1 - 2 prescribed medications daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) 3 + prescribed medications daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Special treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

e.g. Surgery, Radiotherapy, Chemotherapy or Renal Dialysis, please clarify treatment and whether currently or previously received

.....

.....

5. Concerning your mobility, in respect of this condition are you? (please tick box)

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Fully independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Able to walk only with assistance e.g. stick, frame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Wheelchair bound *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) In need of daily nursing care *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Bedridden *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Permanently and irreversibly

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

General Practitioner Details - Applicant 1 (Annuitant)

Doctor's Name

Client's / Patient's Name:

Address

Postcode

Telephone No.

Your Rights under the Access to Medical Reports Act 1988

Before we obtain a report from your doctor we are required to inform you of your rights under the Access to Medical Reports Act 1988, the Access to Personal Files and Medical Reports (NI) Order 1991 and to the Isle of Man: Access to Health Records and Reports Act 1993, under which you may wish to exercise your rights as follows:

- a) you have the right to see the report from your doctor before it is sent, or during the six months after that
- b) you have the right to withhold your consent to your doctor sending a report to any or all of the companies, and
- c) you have the right to ask your doctor to change any parts of the report you consider to be inaccurate or misleading (if your doctor is not in agreement with the changes you may add your own comments to the report).

If you tell us you wish to see the report before it is sent, your doctor must show it to you first, unless you fail to make arrangements to see it within 21 days of the day the company, or companies, made the request for the report. You should be aware that your doctor could withhold the report or part of it from you if he thinks you would be harmed by seeing it.

Declaration - Applicant 1 (Annuitant)

I have been informed of my rights under the Access to Medical Reports Act 1988 and consent to:

Just Retirement
Legal & General
LV= (Liverpool Victoria)
Scottish Widows
MGM Advantage

Partnership Assurance
Prudential
Canada Life
Norwich Union
AXA

seeking medical information concerning my physical or mental health from any doctor who has attended me at any time. I agree that a copy of this consent shall have the validity of the original.

I do not wish to see the medical report before it is sent to any of the companies above
(I am aware that I may approach my doctor with a request to see a copy of the report
within 6 months of its completion)

I wish to see the report before it is sent to any of the companies above

I confirm that to the best of my knowledge and belief the above details are true and complete and understand that this questionnaire shall form part of my application for a pension annuity. I confirm that all facts that might be important in assessing the policies under this application have been provided. I understand that if I have failed to give all relevant facts, the policy issuer may cancel the policies under this application. If I have any doubts as to whether a fact is relevant I will disclose it. I agree that a copy of this consent shall have the validity of the original.

Data Protection Act 1998

I agree that the information the above-named company/companies collect(s) about me, including any sensitive information such as health records, will be used by the company/companies for the purpose of providing an annuity quotation to me and my independent financial adviser. Please refer to the company's own data protection wording for further information on how your data may be used.

Signature:

Date:

General Practitioner Details - Applicant 2 (Dependant)

Doctor's Name

Client's / Patient's Name:

Address

Postcode

Telephone No.

Your Rights under the Access to Medical Reports Act 1988

Before we obtain a report from your doctor we are required to inform you of your rights under the Access to Medical Reports Act 1988, the Access to Personal Files and Medical Reports (NI) Order 1991 and to the Isle of Man: Access to Health Records and Reports Act 1993, under which you may wish to exercise your rights as follows:

- a) you have the right to see the report from your doctor before it is sent, or during the six months after that
- b) you have the right to withhold your consent to your doctor sending a report to any or all of the companies, and
- c) you have the right to ask your doctor to change any parts of the report you consider to be inaccurate or misleading (if your doctor is not in agreement with the changes you may add your own comments to the report).

If you tell us you wish to see the report before it is sent, your doctor must show it to you first, unless you fail to make arrangements to see it within 21 days of the day the company, or companies, made the request for the report. You should be aware that your doctor could withhold the report or part of it from you if he thinks you would be harmed by seeing it.

Declaration - Applicant 2 (Dependant)

I have been informed of my rights under the Access to Medical Reports Act 1988 and consent to:

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | Just Retirement |
| <input type="checkbox"/> | Legal & General |
| <input type="checkbox"/> | LV= (Liverpool Victoria) |
| <input type="checkbox"/> | Scottish Widows |
| <input type="checkbox"/> | MGM Advantage |

- | | |
|--------------------------|-----------------------|
| <input type="checkbox"/> | Partnership Assurance |
| <input type="checkbox"/> | Prudential |
| <input type="checkbox"/> | Canada Life |
| <input type="checkbox"/> | Norwich Union |
| <input type="checkbox"/> | AXA |

seeking medical information concerning my physical or mental health from any doctor who has attended me at any time. I agree that a copy of this consent shall have the validity of the original.

I do not wish to see the medical report before it is sent to any of the companies above
(I am aware that I may approach my doctor with a request to see a copy of the report within 6 months of its completion)

I wish to see the report before it is sent to any of the companies above

I confirm that to the best of my knowledge and belief the above details are true and complete and understand that this questionnaire shall form part of my application for a pension annuity. I confirm that all facts that might be important in assessing the policies under this application have been provided. I understand that if I have failed to give all relevant facts, the policy issuer may cancel the policies under this application. If I have any doubts as to whether a fact is relevant I will disclose it. I agree that a copy of this consent shall have the validity of the original.

Data Protection Act 1998

I agree that the information the above-named company/companies collect(s) about me, including any sensitive information such as health records, will be used by the company/companies for the purpose of providing an annuity quotation to me and my independent financial adviser. Please refer to the company's own data protection wording for further information on how your data may be used.

Signature:

Date: