HARGREAVES LANSDOWN

ANNUITY HEALTH QUESTIONNAIRE

You could get a higher retirement income by confirming your health and lifestyle details. If you are married or have a partner, it's important to include their details too as this could mean more money if you choose a joint life annuity.

Provide as much information as possible to get the best annuity income, and remember to sign on page 15.

Once complete, please return the form to our short freepost address:

Freepost HARGREAVES LANSDOWN

We'll then send your form to Aviva, Canada Life, Just and Legal & General to see what annuity income you could receive.

If you have any questions please call us on 0117 980 9940

Hargreaves Lansdown
One College Square South
Anchor Road Bristol BS1 5HL

0117 980 9940
retire@hl.co.uk
www.hl.co.uk

Your details

Title: Mr/Mrs/Miss/Other Male ☐ Female ☐

Forename:

Surname:

Date of birth: / /

Present occupation: Full-time ☐ Part-time ☐

If no longer working, previous occupation: Date ceased:

Marital Status

Address:

Postcode:

Daytime telephone number:

Evening telephone number:

Email address:

Where are you living:

- ☐ In own home – with spouse, partner or someone else
- ☐ In own home – alone
- ☐ With relatives
- ☐ In a residential home
- ☐ In a care home

Your spouse's or partner's details

Title: Mr/Mrs/Miss/Other Male ☐ Female ☐

Forename:

Surname:

Date of birth: / /

Present occupation: Full-time ☐ Part-time ☐

If no longer working, previous occupation: Date ceased:

Their relationship to you:

Your pension details – The policies you are using to purchase your annuity

Approximate total pension value: £

Tax free cash required (usually 25% max): %

Do your pensions have any guaranteed benefits? Yes ☐ No ☐ Not Sure* ☐

Are you able to take more than 25% tax-free cash from your pensions? Yes ☐ No ☐ Not Sure* ☐

* These benefits are potentially very valuable. They would be lost if you purchased an annuity on the open market. We recommend you try the following to find out more about your pensions:

- Read any documents or letters you have received from your pension provider.
- Contact your provider and ask them if your pension contains any valuable benefits that would be lost on transfer.
- Check if you have ever registered with HM Revenue & Customs for Primary or Enhanced protection against a lifetime allowance charge.

Please don't make any final decision until you have checked for these benefits. If you are unsure about whether to transfer a pension, you should take advice.

The quotation you would like

Do you wish the income to continue to your spouse or partner on your death?
PLEASE TICK ONE ONLY

- ☐ No
- ☐ Yes, in full (100% spouse's pension)
- ☐ Yes, reducing by 1/3 on my death (66.66% spouse's pension)
- ☐ Yes, reducing by 1/2 on my death (50% spouse's pension)

Do you want your income to increase each year?
PLEASE TICK ONE ONLY

- ☐ No, remain the same
- ☐ Yes, increasing by 3% each year
- ☐ Yes, increasing by 5% each year
- ☐ Yes, keeping track with inflation (RPI)

Do you want your income guaranteed for a minimum length of time?
PLEASE TICK ONE ONLY

- ☐ No
- ☐ Yes, guaranteed for _____ years

E.g. 5, 10, 15, 20, 25 or 30

How would you like to receive your quote

The following applies only if you are using our non-advised service. If you are using our advised service your adviser will contact you once all quotes have been received.

Once all quotes have been received we will send you the quote and application pack for the provider offering the highest rate.

Please indicate how you would like this sent:

- ☐ E-mail – We will post a letter to you on receipt of this medical questionnaire which will confirm a password. We will use this password when we e-mail you your quote and application pack. **Please ensure you have included your email address in section A.**
- ☐ Post – We will send your quote and application pack via standard post (note: quotes are only guaranteed for a limited time).

Please now complete the medical questionnaire with as much information as possible to get the best annuity rate. Please provide a photocopy of any doctors' letters if you have them. PLEASE REMEMBER TO SIGN ON PAGE 15.

WHAT HAPPENS NEXT?

On receipt of this completed questionnaire we shall ask for quotations and check the enhancement that may be available. We will send you the quotation, key features and application form for the top provider on our panel that offers your selected quote option. You are under no obligation to proceed with this. The panel for enhanced annuities is selected by Hargreaves Lansdown or by the trustees of your employer's pension scheme. Please note it can take a few weeks to obtain firm quotations, particularly if a doctor's report is required.

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE IN ORDER TO GET THE BEST ANNUITY RATE.
PLEASE REMEMBER TO SIGN ON PAGE 15.

Section 2: Medical Assessment Form – To be completed by you

Please ensure that all details entered are accurate to improve your benefits.

	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 **or** ☐ cms	☐ ins **or** ☐ cms
Do you currently smoke?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please advise year started	__ __ __ __ (Y Y Y Y)	__ __ __ __ (Y Y Y Y)
Have you been a regular **daily** 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 pipe tobacco **or** ☐ Gms pipe tobacco	☐ Ozs rolling tobacco **or** ☐ Gms rolling tobacco ☐ Ozs pipe tobacco **or** ☐ Gms pipe tobacco
If you previously smoked, please advise of the years you started and stopped	__ __ / __ __ / __ __ __ __ (D D / M M / Y Y Y Y) __ __ / __ __ / __ __ __ __ (D D / M M / Y Y Y Y)	__ __ / __ __ / __ __ __ __ (D D / M M / Y Y Y Y) __ __ / __ __ / __ __ __ __ (D D / M M / Y Y Y Y)
How much did you smoke?	☐ Manufactured cigarettes (daily) ☐ Cigars (daily) ☐ Ozs/gms rolling tobacco (weekly) ☐ Pipe (weekly)	☐ Manufactured cigarettes (daily) ☐ Cigars (daily) ☐ Ozs/gms rolling tobacco (weekly) ☐ Pipe (weekly)
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)? If yes, specify date of diagnosis	☐ Yes ☐ No	__ __ / __ __ (M M / Y Y)	☐ Yes ☐ No	__ __ / __ __ (M M / Y Y)
If yes, specify last readings(s)				
Date of reading(s)	__ __ / __ __ (M M / Y Y)	__ __ / __ __ (M M / Y Y)	__ __ / __ __ (M M / Y Y)	__ __ / __ __ (M M / Y Y)
Number and name(s) of medication(s) prescribed (excluding aspirin)				
Have you been diagnosed with high cholesterol? If yes, specify date of diagnosis	☐ 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)
Number and name(s) of medication(s) prescribed				

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE IN ORDER TO GET THE BEST ANNUITY RATE.
PLEASE REMEMBER TO SIGN ON PAGE 15.

Important notes
Please describe as much information about your health as possible before signing this form. All questions asked are relevant, and by providing full and accurate information you will allow an insurer to provide as accurate a quotation as possible. The amount of your annuity income will be based on the medical information supplied. However an insurer may also seek to obtain independent verification of this information from your doctor. If it is subsequently found that the questions were not answered accurately and with reasonable care, then that could result in your income being reduced or your policy being cancelled.

Medical Conditions

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

Other Medical Conditions

For any conditions showing within the Medical Conditions area above, 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).

	Your details	Your dependant's details
Condition 1		
Condition 2		
Condition 3		

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a. 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
b. When did you last experience 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
c. 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
d. 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

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

	☐	☐	☐	☐	☐	☐

f. Have you received any of the following treatments for this condition within the past 5 years? Please tick box.

None	☐	☐	☐	☐	☐	☐
Renal dialysis	☐	☐	☐	☐	☐	☐
Surgery	☐	☐	☐	☐	☐	☐
Please specify						

g.

Your current medication	Dose prescribed	Frequency
1		
2		
3		

Dependant's current medication	Dose prescribed	Frequency
1		
2		
3		

Heart attack, angina and other heart conditions questionnaire

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name: _____

Please complete a separate heart conditions questionnaire if one is required for both you and the dependant.

Have you ever been diagnosed with any of the following?

Diagnosis	Date of diagnosis	No. of occurrences	Ongoing?
Heart attack (Myocardial Infarction)			
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	☐	☐	☐	☐
Breathlessness walking from room to room	☐	☐	☐	☐
Breathlessness climbing stairs	☐	☐	☐	☐
Chest pains on minor to moderate activity	☐	☐	☐	☐
Chest pains on severe exertion	☐	☐	☐	☐
Swollen ankles	☐	☐	☐	☐
Episodes of dizziness	☐	☐	☐	☐
Episodes of blackouts	☐	☐	☐	☐

If surgery has been carried out, please state type of procedure and date of most recent surgery.

Coronary artery bypass graft (CABG)	☐	Number of arteries treated ☐	Date	__ __ / __ __ (M M / Y Y)
Coronary angioplasty/stents	☐	Number of arteries treated ☐	Date	__ __ / __ __ (M M / Y Y)
Aortic valve replacement	☐	Successful? ☐ Yes ☐ No	Date	__ __ / __ __ (M M / Y Y)
Mitral valve replacement	☐	Successful? ☐ Yes ☐ No	Date	__ __ / __ __ (M M / Y Y)
Tricuspid valve replacement	☐	Successful? ☐ Yes ☐ No	Date	__ __ / __ __ (M M / Y Y)
Pacemaker	☐	Successful? ☐ Yes ☐ No	Date	__ __ / __ __ (M M / Y Y)
Cardioversion/ablation	☐	Successful? ☐ Yes ☐ No	Date	__ __ / __ __ (M M / Y Y)
Aortic aneurysm repair	☐	Successful? ☐ Yes ☐ No	Date	__ __ / __ __ (M M / Y Y)

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE IN ORDER TO GET THE BEST ANNUITY RATE.
PLEASE REMEMBER TO SIGN ON PAGE 15.

What medication are you CURRENTLY taking? Please list all medication prescribed for your heart condition:

Name of medication	Name of heart condition	Dose prescribed	Frequency	Date medication commenced
1				
2				
3				
4				
5				

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

Are you currently under the care of a cardiologist? ☐ Yes ☐ No Last consultation date: __ __ / __ __ (M M / Y Y)

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

Date of last admission __ __ / __ __ (M M / Y Y)

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

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

Date	Result (Normal / Abnormal / Other)

Please provide any further information you think may be important. (e.g dates of multiple surgery)

Diabetes questionnaire

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

Please complete a separate diabetes questionnaire if one is required for both you 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)

Is your diabetes? ☐ Type 1 ☐ Type 2

How is your diabetes controlled? ☐ Diet only ☐ Non-insulin (tablet/injection) ☐ Insulin

Please list all the medication you CURRENTLY take, and how often you take each of them, the dosage and date medication commenced.

Medication	Dose prescribed	Date started

If this has changed, please advise your PREVIOUS treatment regimen.

Medication	Dosage	Date started	Date stopped

Have you been diagnosed with any of the following DIABETIC complications? If yes, please give details in the box provided below.

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

Please give the last two readings for **HbA1c:**

Reading 1 ☐ Date: __ __ / __ __ / __ __ __ __ (D D / M M / Y Y Y Y)

Reading 2 ☐ Date: __ __ / __ __ / __ __ __ __ (D D / M M / Y Y 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?

Number of times ☐

Frequency (please tick as appropriate)

☐ daily ☐ weekly ☐ fortnightly ☐ four-weekly
☐ monthly ☐ quarterly ☐ half yearly ☐ annually

Please provide any further information you think may be important.

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE IN ORDER TO GET THE BEST ANNUITY RATE.
PLEASE REMEMBER TO SIGN ON PAGE 15.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

Please complete a separate questionnaire if one is required for both you and the dependant. If you have a history of more than one type of cancer please complete a separate questionnaire for each.

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?

Please tick as appropriate	Stage
☐ TNM	
☐ Modified Astler-Coller (MAC)	
☐ Figo classification	
☐ Dukes classification	
☐ Clark level	
☐ Breslow thickness	
☐ Ann Arbor classification	

Do you know the grading of the tumour? ☐ Yes ☐ No

If yes, please give details:

PLEASE ENCLOSE COPIES OF ANY HOSPITAL LETTERS OR REPORTS ABOUT YOUR CANCER TO CONFIRM THE TYPE OF CANCER, STAGE, GRADE, AND TREATMENT RECEIVED.

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 recorded: __ __ / __ __ (M M / Y Y)

Gleason Score — Date recorded: __ __ / __ __ (M M / Y Y)

In the case of breast cancer, please advise where known

Breast Cancer Hormone Receptor Status

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE IN ORDER TO GET THE BEST ANNUITY RATE.
PLEASE REMEMBER TO SIGN ON PAGE 15.

Did you have, or are you due to have, any of the following as a result of your tumour or malignant condition (eg. Leukaemia):

☐ Surgery	Type of surgery:	Date: __ __ / __ __ (M M / Y Y)

☐ Chemotherapy	Date commenced __ __ / __ __ (M M / Y Y)	Date ended: __ __ / __ __ (M M / Y Y)
☐ Radiotherapy (including brachytherapy)	Date commenced __ __ / __ __ (M M / Y Y)	Date ended: __ __ / __ __ (M M / Y Y)
☐ Bone marrow/stem cell transplant	Date commenced __ __ / __ __ (M M / Y Y)	Date ended: __ __ / __ __ (M M / Y Y)
☐ Hormone therapy	Date commenced __ __ / __ __ (M M / Y Y)	Date ended: __ __ / __ __ (M M / Y Y)
☐ Other (eg. BCG, HIFU, Immunotherapy)		*(Please give full details and advise of date of treatment)*

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

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced
1			
2			
3			
4			
5			

When was your last tumour follow-up appointment with your treating doctor/hospital consultant: __ __ / __ __ (M M / Y Y)

Have you now been discharged? ☐ Yes ☐ No

Please provide any further information you think may be important.

Stroke questionnaire

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

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

Please enclose copies of any hospital letters or reports about your stroke(s).

Please advise which of the following you have been diagnosed with:

☐ CVA (Cerebrovascular Accident – major stroke)
☐ SAH (Subarachnoid Haemorrhage)
☐ Cerebral haemorrhage/bleed
☐ TIA (Transient Ischaemic Attack – mini stroke)

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

Please advise of any of the following ongoing problems due to your stroke:

☐ Speech difficulties
☐ Vision impairment
☐ Paralysis arm
☐ Paralysis leg
☐ Short-term memory loss

What medication are you CURRENTLY taking for this condition?

Name of medication	Dose prescribed	Frequency	Date commenced
1			
2			
3			
4			
5			

Are you under follow-up or have you now been discharged? ☐ Still under follow-up ☐ 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

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

Please complete a separate respiratory/lung disease questionnaire if one is required for both you and the dependant.

Please advise which of the following you have been diagnosed with: **Date of diagnosis**

- ☐ Chronic obstructive airways/pulmonary disease (COAD/COPD) — M M / Y Y
- ☐ Emphysema — M M / Y Y
- ☐ Bronchiectasis — M M / Y Y
- ☐ Pneumoconiosis (a type of lung disease related to occupation) — M M / Y Y
- ☐ Asbestosis — M M / Y Y
- ☐ Asthma — M M / Y Y
- ☐ Pleural plaques — M M / Y Y
- ☐ Sleep apnoea — M M / Y Y

☐ Other Please specify

Is your current lung function:

Unaffected	☐ Yes	☐ No
Minimally impaired (FEV1 greater than 70%)	☐ Yes	☐ No
Moderately impaired (FEV1 50-70%)	☐ Yes	☐ No
Severely impaired (FEV1 less than 50%)	☐ Yes	☐ No

Do any of the following apply due to your respiratory lung condition?	Never	Some of the time	Most of the time	Always
Chest infections	☐	☐	☐	☐
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 steroids (in tablet form only e.g. Prednisolone)	☐	☐	☐	☐

Have you been admitted to hospital for your respiratory/lung disease? ☐ Never ☐ Once ☐ More than once

Last admission M M / Y Y

What medication are you currently taking for your respiratory/lung disease?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Please provide any further information you think may be important.

Multiple sclerosis questionnaire

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

Please complete a separate multiple sclerosis questionnaire if one is required for both you 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?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Have you been admitted to hospital due to your multiple sclerosis? ☐ Never ☐ Once ☐ More than once

Last admission M M / Y Y

Do you have, or have you had, any of the following in relation to your multiple sclerosis?

Bladder incontinence/self-catheterisation	☐ Yes	☐ No
Secondary infection (eg. 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 (eg. prednisolone) on more than 1 occasion	☐ Yes	☐ 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

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

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

Please advise which of the following you have been diagnosed with: **Date of diagnosis**

☐ Senile dementia __ __ / __ __ (M M / Y Y)
☐ Vascular dementia __ __ / __ __ (M M / Y Y)
☐ Alzheimer's disease __ __ / __ __ (M M / Y Y)
☐ Parkinson's disease __ __ / __ __ (M M / Y Y)
☐ Motor neurone disease __ __ / __ __ (M M / Y Y)

☐ Other Please specify (including date of diagnosis)

Have you been admitted to hospital due to your neurological condition? ☐ Never ☐ Once ☐ More than once

Last admission __ __ / __ __ (M M / Y Y)

Do you have, or have you had, any of the following symptoms in relation to your neurological condition?

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

What medication are you currently taking in relation to your neurological condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Please advise last MMSE (Mini Mental State Examination) score if known /30

Please provide any further information you think may be important.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 13

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE IN ORDER TO GET THE BEST ANNUITY RATE.
PLEASE REMEMBER TO SIGN ON PAGE 15.

Activities of Daily Living (ADL) questionnaire

Please indicate who these details relate to

You: ☐ Your Dependant: ☐ Name:

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

Please advise relevant diagnosis in relation to which you are completing this questionnaire:

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

Dressing:

- ☐ Independent (including buttons, zips, laces etc.)
- ☐ Needs help, but can do about half unaided
- ☐ Dependent, requires full assistance

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

Transferring:

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

Bladder:

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

Bowels:

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

Bathing:

- ☐ Independent
- ☐ Needs some assistance
- ☐ Dependent

Feeding:

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

Please advise any progression in the last 5 years:

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

Current Data Protection Laws and Future Legislation

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. You can understand how we use and share your personal data by reading and retaining the generic Privacy Notice accompanying this application (page 16) or reviewing each Provider's full Privacy/ Data Protection Notice from their website. Their web addresses are on the first page of the accompanying Privacy Notice.

Your data will be processed fairly and securely in accordance with current Data Protection laws and future legislation and may be passed to organisations outside of the Provider for the provision of underwriting, administration, claims management, rehabilitation and customer concern handling services and may also be shared with group companies and third party insurers, re-insurers, insurance intermediaries and service providers.

Furthermore, your 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 Provider's Medical Officer or equivalent.

Your personal data will only be available to those who need that information and you have the right to receive a copy of all your personal data held by contacting either your Financial Adviser, the Provider or by writing to the Provider's Data Protection Officer.

Please note that during the processing of any proposals and administration, information may be transferred outside the European Economic Area.

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 the information and statements provided above are true and I/we have taken reasonable care to ensure that my/our answers to the questions asked are correct. I/We understand that if any information provided by me/us is subsequently found to be inaccurate the policy may be amended or cancelled in accordance with the Consumer Insurance (Disclosure and Representations) Act 2012. I understand that this may mean the benefits payable to me/us are reduced and in some instances the policy may be cancelled.

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 unless I/we advise the Provider otherwise.

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 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 that a copy of this declaration and consent can be treated as the original.

I/We agree to the Provider processing my/our medical data in accordance with the Privacy Notice, a copy of which has been provided to me/us.

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 or cancellation of the policy in accordance with the Consumer Insurance (Disclosure and Representations) Act 2012.

I/We have been duly notified of my/our rights under the Access to Medical Information legislation as detailed overleaf governing access to medical records.

I/We understand that 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.

YOU – I do ☐ do not ☐ wish to see the report before it is sent to the Provider

YOUR DEPENDANT – I do ☐ do not ☐ wish to see the report before it is sent to the Provider

The personal and medical information in this form will be shared with the following providers:

☑ Aviva ☑ Canada Life ☑ Just ☑ Legal & General

This will allow them to provide you with annuity quotations.

If you provide consent below, these providers will share the information in this form with other companies to obtain a market-leading comparison quote to see if you could receive more annuity income with another provider.

I/We do ☐ do not ☐ consent for my/our personal and medical information to be shared with other companies for the purpose of obtaining a market-leading comparison quote.

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.

	YOU	DEPENDANT
Doctor's Name		
Doctor's Address		
Telephone number		
Fax number		

	YOU	DEPENDANT
Name (BLOCK CAPITALS)		
Signature		
Date	__ __ / __ __ / 2 0 __ __ (D D / M M / Y Y Y Y)	__ __ / __ __ / 2 0 __ __ (D D / M M / Y Y Y Y)

Privacy Notice

All the Product Providers; Aviva, Canada Life, Just and Legal & General that take part in the Retirement Health Form Service (referred to as “Product Providers” or “we” in this Privacy Notice (PN)) take their privacy obligations very seriously. Any personal information provided to them, as Data Controllers, by a policyholder, joint policyholder, employer policyholder, trustee, insured person, beneficiary, claimant or member (referred to as ‘you’ or ‘your’ in this PN), will be treated in accordance with current Data Protection legislation, and any successor legislation. This is a generic PN which explains how the Product Providers may use your personal information. Full details of how each Provider will use your data can be found on their websites:

Aviva - www.aviva.co.uk/legal/privacy-policy.html

Canada Life - www.canadalife.co.uk/data-protection-notice

Just - www.wearejust.co.uk/privacy-policy

Legal & General - www.legalandgeneral.com/privacy-policy

What is personal information?

Personal information means any information about you which is personally identifiable, including your name, age, address, telephone number, email address, financial details, and any other information from which you can be identified. It will also include genetic and biometric data, location data and online identifiers which may identify you, such as your internet protocol (IP) address (the unique personal address which identifies your device on the internet) and mobile device IDs.

What do we collect?

The Product Providers will collect the following information about you and your dependants (this includes your authorised Power of Attorney) when you use their services or they may collect it indirectly from their business partners, such as financial intermediaries:

- Personal data: your name, date of birth, telephone number, address, email address, dependants, marital status, IP address and media access control (MAC) address.
- Sensitive/special categories of personal data: gender and other sensitive information such as information about your physical and mental health. They recognise that information about health is particularly sensitive information. Should consent be the legal basis of processing special categories of personal data, they will ask for consent to collect and use this information.
- Financial information: information that may relate to your financial circumstances (for example your pension values, income and existing investments), bank account details and details of product options you may consider.
- Technical Information: such as details on the devices and technology you use.
- Public Records: This includes open data such as the Electoral register, Land register or information that is openly available on the internet.
- Documentary data and national identifiers: Information that is stored on your passport, driving license, birth certificate, and National Insurance number.

As well as collecting personal information about you, they may also use personal information about other people, for example family members you wish to insure on a policy. If you are providing information about another person, the Product Providers expect you to ensure the other person knows you are doing so and are content with their information being provided to them. You might find it helpful to show them this PN and if they have any concerns to contact the relevant Product Provider(s) directly. If personal information is submitted about another person (for example spouse/partner), then by signing this form, you confirm that they have consented to providing their information for the information to be used and shared as set out in this notice.

How we use the information we collect

Product Providers on this form will use personal information collected from you and personal information about you obtained from other sources such as your financial intermediary in the following ways:

- To provide you with your required policy;
- To decide what terms, they can offer;
- To administer your policy;
- To support legitimate interests that they have as a business;
- To prevent, detect or investigate financial crime;
- To help them better understand their customers and improve customer engagement. This may include research; statistical analysis, profiling and customer analytics which allows them to make certain predictions and assumptions about your interests, and make correlations about their customers to improve their products;
- To meet any applicable legal or regulatory obligations: they need this to meet compliance requirements with their regulators (e.g. Financial Conduct Authority), to comply with law enforcement and to manage legal claims; and
- To carry out other activities that are in the public interest: for example, they may need to use personal information to carry out anti-money laundering checks.

Some of the information they collect as part of an application for a policy may be provided to them by a third party. This may include information Product Providers and their subsidiaries already hold about you and your dependant, including details from previous quotes and claims, information they obtain from publicly available records, their trusted third parties and from industry databases, including fraud prevention agencies and databases.

Legal basis for processing Personal Data

Where processing of data is necessary for entering into a contract with a Product Provider or for the performance of a contract which you (the data subject) are aware of the legal processing of Personal Data, this is based on Article 6.1(b) of the General Data Protection Regulation (GDPR).

Processing of Special Categories of Personal Data (for example health or medical data) is based on Article 9.2(g) of the GDPR in that processing is necessary for reasons of substantial public interest and conducted on the basis of applicable law where the only data processed will be that necessary for the aim specified in order to respect the Data Subject's rights and interests.

Who your Personal Information may be shared with

The personal information a Product Provider holds about you may be shared with the following recipients subject to security, contractual and transfer adequacy safeguards as appropriate:

(a) their group affiliates (where they exist);
(b) their agents;
(c) their business partners/service providers who assist them in providing the services they offer;
(d) doctors or any relevant medical professional; and
(e) credit agencies (for the purpose of identification verification).

The following categories of agents, business partners and close affiliations assist them in the provision of ancillary services and they only use your personal information to the extent necessary to perform their functions:

- Providers for pricing/underwriting purposes: these Providers may share your personal information with their group companies for the same purpose;
- Service providers: for the provision of support services such as reinsurance, product administration, receiving and sending marketing communications, data analysis and validation, IT support services, archiving, auditing, business administration and other support services and tasks, from to time;
- Business partners who may have referred you to us: to provide them with relevant management information;
- Other companies in the event we undergo a re-organisation or are sold to a third party;
- Regulators and public authorities who have a legal right to request and process your personal information e.g. the FCA, HMRC and the DWP;
- Other subsidiary companies, where relevant, for management information purposes;
- In addition, a Product Provider may disclose your personal information if legally entitled or required to do so, for example, if required by law or by a court order or if they believe that such action is necessary to prevent fraud or cybercrime or to protect their website or the rights of individuals or their property or the personal safety of any person.

How long Product Providers will keep your Personal Information for

Product Providers maintain a retention policy to ensure they only keep personal information for as long as they reasonably need it for the purposes explained in this notice. They need to keep information for the period necessary to administer your insurance and deal with claims and queries on your policy. They may also need to keep information after their relationship with you has ended, for example, to ensure they have an accurate record in the event of any complaints or challenges, carry out relevant fraud checks, or where they are required to do so for legal, regulatory or tax purposes.

Anonymised personal information will not be considered as personal since no individual can be identified by that information. Product Providers may use anonymised personal information for further actuarial and business analysis, business research and reporting to help develop their products and services.

Transmission and Security of Personal Information

Product Providers have security measures in place to protect against the loss, misuse and alteration of personal information under their control as required by current Data Protection laws and, as of May 2018, the EU GDPR.

For example, Product Providers' security and privacy policies are periodically reviewed and enhanced as necessary and only authorised personnel have access to personal information. Whilst they cannot ensure or guarantee that loss, misuse or alteration of information will never occur, they will use all reasonable efforts to prevent it.

Data Transfer outside of the European Economic Area (EEA)

Given the global nature of some Product Providers' businesses, some will use third party suppliers and outsourced services (including Cloud-based services), which can require transfers of personal information outside of the EEA. In doing so, Product Providers will ensure that there are appropriate contractual arrangements in place and will choose only those organisations with strict controls via appropriate organisational and technical measures to protect your personal information.

Notification of Changes to Privacy Policy

Product Providers will reserve the right to amend or modify the Privacy Policy at any time and in response to any changes in applicable Data Protection and privacy legislation.

If Product Providers decide to change their Privacy Policy, they will post these changes on their websites so that you are aware of the information they collect and use it at all times.

If at any point Product Providers decide to use or disclose information they have collected, in a manner different from that stated at the time it was collected, they will notify you.

Individual rights under the General Data Protection Regulation

From 25th May 2018 individuals (Data Subjects) are provided with various rights including the right to be told what Personal Data is held by Product Providers and the right to request that any inaccuracies in respect of your Personal Data are corrected. Details of all individual rights are shown below:

1. **The right to be informed** – you have the right to be informed how your Personal Data will be used. For example, this may be set out in a company's Privacy Notice.
2. **The right of access** – you have the right to access your Personal Data and supplementary information. For example, you may wish to access your data to become aware of and verify the lawfulness of the processing.
3. **The right to rectification** – you have the right to have your Personal Data rectified. For example, if you feel it is inaccurate or incomplete.
4. **The right to erasure** – you have the right in specific circumstances to request the deletion or removal of Personal Data where there is no compelling reason for its continued processing. For example, your Personal Data was unlawfully processed.
5. **The right to restrict processing** – you have the right to restrict the processing of your Personal Data in certain circumstances. For example, you wish to contest the accuracy of your Personal Data.
6. **The right to data portability** – you have the right to obtain and reuse your Personal Data for your own purposes. For example, you may wish to move, copy or transfer Personal Data from one information technology environment to another in a safe and secure manner.
7. **The right to object** – you have the right to object to your Personal Data being used for processing based on legitimate interests or for a task in the public interest. For example, you no longer want your Personal Data used for direct marketing.
8. **Rights in relation to automated decision making and profiling** – you have the right to challenge decisions that are made using an automated approach including profiling. For example, you may want to request human intervention where you do not agree with an automated decision.

Contact Details:

Any enquiries relating to Data Protection issues should be sent to a Provider at the Data Protection address which can be found from their website.

You also have the right to talk to the Information Commissioner's Office whose main role is to uphold information rights in the public interest.

Website: ico.org.uk/for-the-public

Email: casework@ico.org.uk

Phone: 0303 123 1113

Address: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF