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.

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	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
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	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Are you living	☐ In own home – alone ☐ In own home – with someone else ☐ With relatives ☐ In a residential home ☐ In a care home	☐ 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

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	Y Y Y Y	Y Y Y Y
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	M M / Y Y to M M / Y Y	M M / Y Y to M M / Y Y
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	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 (excluding aspirin)	☐		☐	
Have you been diagnosed with high cholesterol	☐ 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	☐		☐	

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).

	Condition 1	*Condition 2*	*Condition 3*	*Condition 1*	*Condition 2*	*Condition 3*
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.

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

None	☐	☐	☐	☐	☐	☐
Renal dialysis	☐	☐	☐	☐	☐	☐
Surgery	☐	☐	☐	☐	☐	☐
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 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	☐	☐	☐	☐
Breathlessness walking from room to room	☐	☐	☐	☐
Breathlessness climbing stairs	☐	☐	☐	☐
Chest pains on minor to moderate activity	☐	☐	☐	☐
Chest pains on severe exertion only	☐	☐	☐	☐
Swollen ankles	☐	☐	☐	☐
Episodes of dizziness	☐	☐	☐	☐
Episodes of blackouts	☐	☐	☐	☐

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

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

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: __ __ / __ __ (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

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

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

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

If yes, please give details:

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

Reading 1 ____ Date: __ __ / __ __ (M M / Y Y)

Reading 2 ____ Date: __ __ / __ __ (M M / Y Y)

Have you ever been admitted into hospital as a result of your diabetes? ☐ Yes ☐ No If yes, when? __ __ / __ __ (M M / Y Y)

How often do you monitor your own blood glucose levels?

Please provide any further information you think may be important.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Annuitant: ☐ Dependant: ☐

Name:

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

Please enclose copies of any hospital letters or reports about your cancer to confirm the type of cancer, stage, grade and treatment received.

What is the name or type of the tumour/malignant condition?

Where was the tumour located?

When was the tumour/condition first diagnosed?

Was the tumour: ☐ Benign ☐ Pre-cancerous ☐ Malignant

Do you know the staging of the tumour, for example TNM or Duke classification? ☐ Yes ☐ No

If yes, please give details:

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

If yes, please give details:

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

☐ Carcinoma-in-situ (stage O, Tis, Ta) ☐ Only local tumour growth

☐ Tumour invaded adjacent lymph nodes ☐ Tumour invaded distant lymph nodes

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

☐ Tumour spread to distant organs (distant metastases) If so, where:

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

Current Prostate Specific Antigen (PSA) level: Date recorded: __ __ / __ __ (M M / Y Y)

Pre-treatment PSA level: Date: __ __ / __ __ (M M / Y Y)

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

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

☐ 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 _____ *(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: __M __M /__Y __Y

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	☐	☐	☐	☐
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	☐	☐	☐	☐

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	☐ 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

Annuitant: ☐ Dependant: ☐

Name:

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

Have you ever been diagnosed with any of the following?

- ☐ Senile dementia
- ☐ Vascular dementia
- ☐ Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Motor neurone disease
- ☐ Other Please specify:

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

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

When was your condition diagnosed? __ __ / __ __ (M M / Y Y)

Have you had any of the following symptoms?

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

What medication are you currently taking?

Medication	Dose/frequency	Date commenced	Date ended

Please advise last MMSE 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

Activities of Daily Living (ADL) questionnaire

Annuitant: ☐ Dependant: ☐

Name:

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

Please advise relevant diagnosis:

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

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

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

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

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

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

Bathing:
- ☐ Dependent
- ☐ Needs some assistance
- ☐ Independent

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

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:

☐ Canada Life ☐ Just Retirement ☐ Legal & General ☐ Aviva ☐ MGM Advantage
☐ Partnership ☐ Prudential ☐ 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.

	ANNUITANT	DEPENDANT
Doctor's Name		
Address		
Telephone number		
Fax number		

	ANNUITANT	DEPENDANT
Name (BLOCK CAPITALS)		
Signature		
Date	__ __ / __ __ / __ __ __ __ D D M M Y Y Y Y	__ __ / __ __ / __ __ __ __ D D M M Y Y Y Y

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 D D / M M / Y Y Y Y

	Value
Non-protected rights benefits	
Pre 06/04/1997	£
Post 05/04/1997	£
Protected rights/contracted out benefits	Value
Pre 06/04/1997	£
Post 05/04/1997	£

	Value	Escalation rate	Revaluation rate
GMP/related benefit			
Pre 06/04/1988	£	%	%
Post 05/04/1988	£	%	%

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:

Phone:
0845 300 2837

Email:
ENQUOTE@aviva.co.uk

Fax:
0845 304 1122

Web:
www.aviva.co.uk

Post:
Annuity New Business Team, FAO Angela Patterson, PO Box 520, Surrey Street, Norwich NR1 3WG

Phone:
01707 421992

Email:
ifa_sales_support@canadalife.co.uk

Fax:
01707 671194

Web:
www.canadalife.co.uk/ifazone

Post:
Sales Support Canada Life Limited, Canada Life Place, Potters Bar, Hertfordshire EN6 5BA.

Phone:
0845 302 2287

Email:
ifasupport@justretirement.com

Fax:
0845 301 2287

Web:
www.justretirement.com

Post:
Vale House, Roebuck Close, Bancroft Road, Reigate, Surrey RH2 7RU

Phone:
08456 740 747

Email:
nsa.team@landg.com

Fax:
02920 354 684

Web:
www.legalandgeneral.com/advisercentre

Phone:
0800 169 11 11

Email:
annuity.quotes@lv.com

Fax:
0870 243 0078

Web:
www.lvadviser.co.uk

Post:
LV= Retirement Solutions, Keynes House, Tilehouse Street, Hitchin, Herts, SG5 2DX

Phone:
0845 608 6070

Email:
ifaservice@mgmadvantage.com

Fax:
0845 601 6070

Web:
mgmadvantage.com

Post:
MGM Advantage, MGM House, Heene Road, Worthing, West Sussex, BN11 3AT

V2 CQF00006 03/10

Phone:
0845 108 7237

Email:
retirement@partnership.co.uk

Fax:
0845 108 7238

Web:
www.partnership.co.uk

Post:
Sackville House, 143-149 Fenchurch Street, London EC3M 6BN

Phone:
0808 234 5100

Email:
enhanced.annuities@prudential.co.uk

Fax:
0845 600 3658

Web:
www.pruadviser.co.uk

Post:
FREEPOST, Prudential, Stirling, FK9 4UE