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 or completely then that could result in your income being reduced.

Enhanced Pension Annuity Quotation Request Form

You/Dependant to complete sections 1+2

Financial Adviser to complete sections 3+4

For more information visit www.commonquotation.co.uk
(this includes details on how to complete this Quotation Request Form).

Quote Reference No. *(if applicable)*

Source of quote

Section 1: Personal Details – To be completed by you

Please complete this form using black ink and capital letters

	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		
If no longer working, previous occupation	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time
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 2 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.

If you have a Financial Adviser, please request them to fill in sections 3 and 4.

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				

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 or completely then that could result in your income being reduced.

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 is completing

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)

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 is completing

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.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please indicate who is completing

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

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 is completing

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 is completing

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 __ __ / __ __
- ☐ Bronchiectasis __ __ / __ __
- ☐ Pneumoconiosis (a type of lung disease related to occupation) __ __ / __ __
- ☐ Asbestosis __ __ / __ __
- ☐ Asthma __ __ / __ __
- ☐ Pleural plaques __ __ / __ __
- ☐ Sleep apnoea __ __ / __ __
- ☐ 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 is completing

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 is completing

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

Activities of Daily Living (ADL) questionnaire

Please indicate who is completing

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)

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' 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. ☐ You ☐ Dependant

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 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		
Address		
Telephone number		
Fax number		

	YOU	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

If you have a Financial Adviser, this section should be completed by them.

What was the basis of sale *(please tick)*

- ☐ Advised – Independent
- ☐ Advised – Restricted
- ☐ Advised – Simplified
- ☐ Non-Advised – Execution Only
- ☐ Non-Advised – No Advice
- ☐ Non-Advised – Direct Offer

Name of Firm

Contact Name

Company Address

Postcode

E-mail

FSA Reference Number

Telephone Number

Facsimile Number

Adviser Remuneration

Please note that a copy of the Service Agreement will need to be provided at the point of application.

a) Adviser Charge

☐ Not to be facilitated by the annuity provider

Initial Adviser Charge facilitated by the annuity provider

£ (Monetary Amount)

or

% (Percentage)

Where should the Initial Adviser Charge be deducted from *(please tick)*?

- ☐ Total purchase money*
- ☐ Purchase money after the payment of any Pension Commencement Lump Sum (tax free cash)*
- ☐ Pension Commencement Lump Sum (tax free cash)**

* Please note this is only available from providers who support these options.

**Please note that if Adviser Charge is deducted from Pension Commencement Lump Sum this will reduce the amount paid to the client. This is only available from providers who support this option.

On-going Adviser Charge facilitated by the annuity provider***

£ (Monetary Amount) and (Frequency)

or

% (Percentage)

*** Please note this is only available with products that support this option.

b) Commission (only available on Non-Advised Sales)

£ (Monetary Amount)

or

% (Percentage)

or

☐ Nil Commission

How would you prefer to receive the quote? ☐ Post ☐ Fax ☐ Email

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 application and administration, information may be transferred outside the European Economic Area.

For a full explanation regarding confidentiality, please read the data protection statement on page 14.

Section 4: Pension Details

If you have a Financial Adviser, please ask them to assist you with the completion of this page.

Note: Not all of the life offices may offer these options, for example RPI escalation may only be available from certain offices. You will need to contact each office for more information. Please photocopy this page if you are requesting 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

Name of ceding pension provider/s

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)

Pension benefits £

If applicable GMP/related benefit	**Value**	**Escalation rate**	**Revaluation rate**
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 annuitant's 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 Investment Linked Annuity quotations? (Offered by LV=, Prudential and MGM) ☐ Yes ☐ No

If yes, please state the level of return to be assumed: % please specify ☐ Max

For unit linked products, please state the % benchmark: ☐ 50% ☐ 100% ☐ 120% or ☐ Max or other % please specify

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:

Please attach extra sheets if you require additional space.

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