The Retirement Health Form

Enhanced pension annuity quotation request form

Providers participating in the Retirement Health Form:

AVIVA · canada life · JUST. · Legal & General · SCOTTISH WIDOWS

You/Your dependant to complete sections 1 & 2
Please ensure you complete and sign the Declaration and Consent page at the end of Section 2.

Financial Adviser to complete sections 3 & 4

Section 1
Personal Details

Section 2
Medical Assessment

Section 3
Financial Adviser's Details

Section 4
Pension Details

For more information visit www.retirementhealthform.co.uk
(this includes details on how to complete this form).

IMPORTANT NOTES
Please describe in 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.

Section 1: **Personal Details**

To be completed by you and your dependant.
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
Forename(s)		
Surname		
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
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	M M / Y Y	M M / 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
House name/number		
Address		
Postcode		
Email address		

NOW PLEASE COMPLETE THE MEDICAL ASSESSMENT FORM IN SECTION 2 AND ANY OTHER QUESTIONNAIRE AS DIRECTED.

Section 2: **Medical Assessment**

To be completed by you and your dependant.
Please ensure that all details entered are accurate to improve your benefits.

	Your details	Your dependant's details
1. Height	☐ ft ☐ ins **or** ☐ cms	☐ ft ☐ ins **or** ☐ cms
2. Weight	☐ st ☐ lbs **or** ☐ kgs	☐ st ☐ lbs **or** ☐ kgs
3. Waist measurement	☐ ins **or** ☐ cms	☐ ins **or** ☐ cms
4. Do you currently smoke?	☐ Yes ☐ No	☐ Yes ☐ No
a) If yes, please advise month/year started	M M / Y Y	M M / Y Y
b) Have you been a regular **daily** smoker for the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
c) If you are a regular smoker, please indicate the average **daily** level	☐ Manufactured cigarettes ☐ Cigars	☐ Manufactured cigarettes ☐ Cigars
d) If you are a regular smoker, please indicate the average **weekly** level	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)
5. If you previously smoked, please advise of the months/years you started and stopped	M M / Y Y M M / Y Y	M M / Y Y M M / Y Y
a) If you were a regular cigarette and/or cigar smoker, please indicate the average **daily** level	☐ Manufactured cigarettes ☐ Cigars	☐ Manufactured cigarettes ☐ Cigars
b) If you were a regular rolling tobacco/or pipe smoker, please indicate the average **weekly** level	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)	☐ Rolling tobacco (Gms) ☐ Pipe tobacco (Gms)
6. How many units of alcohol do you drink **weekly**?	☐	☐

Guidance Note: A unit of alcohol is equivalent to half a pint of normal strength beer, lager, or cider, one small (125ml) glass of wine, or a single measure of spirit.

7. Have you been diagnosed with high blood pressure (hypertension)? ☐ Yes ☐ No ☐ Yes ☐ No

a) If yes, specify date of diagnosis __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y)

b) If yes, specify last readings(s)

Guidance Note: Blood pressure readings required are those taken by your GP/Clinician rather than home self-testing kits.

c) Date of reading(s) __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y)

d) Name(s) of medication(s) prescribed (excluding aspirin)

8. Have you been diagnosed with high cholesterol? ☐ Yes ☐ No ☐ Yes ☐ No

a) If yes, specify date of diagnosis __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y)

b) If yes, specify last reading(s)

Guidance Note: Cholesterol readings required are those taken by your GP/Clinician rather than home self-testing kits.

c) Date of reading(s) __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y) __ __ / __ __ (M M / Y Y)

d) Name(s) of medication(s) prescribed

IMPORTANT NOTES

The amount of your annuity income will be based on the medical information supplied. 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. 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.

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 other conditions, please complete the questions below (and, if relevant, the Activities of Daily Living questionnaire on page 16). If you or your dependant have more than 3 conditions, please use a separate form to submit details of the other conditions.

	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	Dosage	Frequency
1		
2		
3		

Dependant's current medication	Dosage	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.
Please refer to any available hospital letters or reports about your heart condition to complete this section.
You may also include copies of any reports with your request form.

Have you ever been diagnosed with any of the following?

Diagnosis	Date of diagnosis (MM/YY)	No. of occurrences	Condition ongoing? (yes/no)
Heart attack (Myocardial Infarction)			Not Applicable
Angina			
Heart failure			
Aortic aneurysm			
Cardiomyopathy			
Heart valve disorders			
Atrial fibrillation (AF)			
Other irregular heart rhythm			
Other: please specify (e.g. blocked artery) _____			

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:

Medication name	Name of heart condition(s)	Dosage	Frequency	Date commenced (MM/YY)
1				
2				
3				
4				
5				

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

How many times have you been admitted to hospital due to your heart condition WITHIN THE 10 PAST YEARS?

Number of hospital admissions ☐ 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.
(Do not include resting ECG tests.)

Date	Result
	Normal / Abnormal / Other **(Please delete as appropriate)**

Please provide any further information you think may be relevant e.g. dates of multiple surgery, or other surgery types not covered above (please specify).

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 refer to any available hospital letters or reports about your diabetes to complete this section.
You may also include copies of any reports with your request form.

When was your diabetes diagnosed? 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 for your diabetes?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

Have you been diagnosed with any of the following DIABETIC complications? If yes, please select as appropriate giving details with dates 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: (Please record readings either as mmol/mol or as a percentage)

Guidance Note: HbA1c readings can be reported as mmol/mol or as a percentage. Mmol/mol readings are usually higher figures between 40 mmol/mol and 140+ mmol/mol; whereas percentage readings are usually lower figures between 3.0% and 16.0%. (Please do not advise results of glucose finger prick tests, fasting blood sugar tests or random blood sugar tests here.)

HbA1c Reading 1 mmol/mol or % Date: M M / Y Y

HbA1c Reading 2 mmol/mol or % 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

If you monitor your own blood glucose levels how frequently do you monitor it? Number of times ☐

Frequency (please tick as appropriate)

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

Please provide any further information you think may be important.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please refer to and/or include any available hospital letters or reports about your cancer, stage, grade and treatment received to complete this section.

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 and its location?

When was the tumour/malignant condition first diagnosed? __/__ (M M / Y Y)

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

If you know the clinically confirmed staging of the tumour, please tick and provide details against the relevant classification below:

General Classification (used for all cancers e.g. Stage 1B):

Stage: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Sub-stage (1-4 only) ☐ A ☐ B ☐ C

TNM (commonly used for most cancers e.g. T1aN0M0)

T Stage ☐ Ta ☐ Tis ☐ TX ☐ T0 ☐ T1 ☐ T2 ☐ T3 ☐ T4 Sub-stage (T1-T4 only) ☐ a ☐ b ☐ c

N Stage ☐ NX ☐ N0 ☐ N1 ☐ N2 ☐ N3 Sub-stage (N1-N3 only) ☐ a ☐ b ☐ c

M Stage ☐ MX ☐ M0 ☐ M1

Dukes classification (used for colorectal cancers)

Stage: ☐ A ☐ B ☐ C ☐ D

Modified Astler-Coller (MAC) (used for colorectal cancers):

Stage ☐ A ☐ B1 ☐ B2 ☐ B3 ☐ C1 ☐ C2 ☐ C3 ☐ D

Figo classification (used for gynaecological cancers)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Clark level (used for skin cancers, specifically malignant melanomas)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Breslow thickness (used for skin cancers, specifically malignant melanomas)

Details: ☐ mm

Ann Arbor classification (used for lymphomas)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Do you know the clinically confirmed grade of the tumour? ☐ Yes ☐ No

If yes, please tick appropriate option ☐ Grade 1 (Low) ☐ Grade 2 (Intermediate) ☐ Grade 3 (High)

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
If ticked, please advise number of nodes affected and location

☐ Tumour invaded distant lymph nodes
If ticked, please advise number of nodes affected and location

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

Guidance Note: The removal of lymph nodes for biopsy does not necessarily mean the cancer has spread there.

In the case of PROSTATE CANCER, please advise where known

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

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

Gleason Score — Date: __/__ (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:

☐ 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)*
(e.g. BCG, HIFU, Immunotherapy) — Date: __/__ (M M / Y Y)

What medication are you CURRENTLY taking for this condition?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

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

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 refer to any available hospital letters or reports about your stroke(s) to complete this section.
You may also include copies of any reports with your request form.

Please advise which of the following you have been diagnosed with and give details of all episodes below:

☐ 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 (i.e. number of hours or days)	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?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

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

Please provide any further information you think may be important.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 16

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 refer to/include any available hospital letters or reports as necessary.

Please advise which of the following respiratory conditions 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	__ __/__ __ (M M / Y Y)

How has your lung function been graded according to FEV1? (This does not refer to Peak Flow):

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)	☐	☐	☐	☐

If you have been admitted to hospital for your respiratory/lung disease, how many times have you been admitted and please indicate date of last admission?

Number of hospital admissions ☐ Date of last admission __ __/__ __ (M M / Y Y)

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

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

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. Please refer to any available hospital letters or reports about your multiple sclerosis to complete this section. You may also include copies of any reports with your request form.

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 name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			

If you have been admitted to hospital due to your multiple sclerosis, please indicate how many times you have been admitted and the date of your last admission?

Number of hospital admissions ☐ Date of 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 (e.g. pneumonia)	☐ Yes	☐ No
Progressive mental deterioration	☐ Yes	☐ No
Vision impairment	☐ Yes	☐ No
Speech impairment	☐ Yes	☐ No
Paralysis of a limb	☐ Yes	☐ No
Use of steroids (e.g. 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 16

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 refer to any available hospital letters or reports about your other neurological conditions to complete this section. You may also include copies of any reports with your request form.

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

☐ Vascular dementia — Date of diagnosis: __/__ (M M / Y Y)

☐ Alzheimer's disease — Date of diagnosis: __/__ (M M / Y Y)

☐ Dementia (not otherwise specified above) — Date of diagnosis: __/__ (M M / Y Y)

☐ Parkinson's disease — Date of diagnosis: __/__ (M M / Y Y)

☐ Motor neurone disease — Date of diagnosis: __/__ (M M / Y Y)

☐ Other Please specify — Date of diagnosis: __/__ (M M / Y Y)

If you have been admitted to hospital for your neurological condition, how many times have you been admitted and please indicate date of last admission?

Number of hospital admissions ☐ Date of 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?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			

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

Please provide any further information you think may be important, e.g. the result of any other cognition assessment.

PLEASE ALSO COMPLETE THE ACTIVITIES OF DAILY LIVING QUESTIONNAIRE ON PAGE 16

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: How is your ability to dress yourself?

- ☐ I am able to fully dress myself (including buttons, zips, laces etc.)
- ☐ I am able to dress myself but require some assistance with buttons, zips and laces etc.
- ☐ I require full assistance to dress myself

Mobility Indoors: How easily you can move from one place to another?

- ☐ I can independently move from one place to another
- ☐ I walk with assistance (frame/stick/rolling walker)
- ☐ I use a wheelchair some of the time
- ☐ I use a wheelchair always
- ☐ I require full assistance of one or two people
- ☐ I am bedridden

Transferring: How well are you able to move from one position to another, e.g. from a chair to a bed?

- ☐ I am able to get into a chair or bed independently
- ☐ I require the assistance or supervision of one person to get into a chair or bed
- ☐ I require the assistance of two people to get into a chair or bed
- ☐ I am unable to transfer and require a hoist to transfer

Bladder Control: How would you describe your current bladder control?

- ☐ I am in full control of my bladder
- ☐ I have occasional accidents
- ☐ I am unable to control my bladder or I am catheterised

Bowel Control: How would you describe your current bowel control?

- ☐ I am in full control of my bowel movements
- ☐ I have occasional accidents
- ☐ I have no control of my bowel movements

Bathing and Showering: How easy is it for you to bathe and get in and out of the bath or shower?

- ☐ I can independently wash and bathe myself
- ☐ I can wash independently but require assistance in and out of the bath or shower
- ☐ I require full assistance to bathe or shower

Feeding: What is your current ability to feed yourself once food has been prepared and made available?

- ☐ I can independently feed myself
- ☐ I require assistance to cut up the food on my plate but I am able to feed myself
- ☐ I am unable to feed myself or require a naso-gastric/ PEG tube

How has your ability to perform your ADL changed over the last 5 years?

- ☐ I have experienced no change; or deterioration in only one activity
- ☐ I have experienced deterioration in two or more activities
- ☐ I have experienced deterioration in two or more activities within the last 12 months

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 24) 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

Has Power of Attorney been vested in another party?

☐ Yes ☐ No *If yes, please enclose the appropriate documentation*

If so, which type? ☐

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 information provided in this form will be shared with Aviva, Canada Life, Just, Legal & General and Scottish Widows to allow them to provide you with an Annuity quotation. These Providers will share your personal and medical information and, if applicable, your dependant's personal and medical information contained in this form with other companies to obtain a market leading comparison quote (in accordance with Financial Conduct Authority regulations) to see if you could receive more annuity income with another Provider.

YOU - I 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 (in accordance with Financial Conduct Authority regulations).

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 Privacy Notice regarding the Data Protection Legislation on page 24.

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

	YOU	YOUR DEPENDANT
Name (BLOCK CAPITALS)		
Signature		
Date of Signature	__ __ / __ __ / __ __ __ __ D D M M Y Y Y Y	__ __ / __ __ / __ __ __ __ D D M M Y Y Y Y

Section 3: **Financial Adviser's Details**

Financial Adviser to complete this section.

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

- ☐ Advised – Independent
- ☐ Advised – Restricted
- ☐ Non-Advised

Name of Firm	
Contact Name	
RI/Adviser Name	
Company Address	
Postcode	
Email	
PRA and /or FCA Reference Number	
Telephone Number	

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.

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

£ _____ (Monetary Amount)

or

_____ % (Percentage)

or

☐ Nil Commission

Section 4: **Pension Details**

Financial Adviser to complete this section.

Quote Reference No. *(if applicable)*

Source of quote

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

Only complete one box

Total purchase price	£	Before payment of pension commencement lump sum (tax free cash)
Fund value	£	Net amount after payment of pension commencement lump sum (or GAR value)
Income required	£	The quote will calculate the purchase price required to secure the specified income amount.

Source of funds

Name of ceding pension provider/s

Protected Pension Commencement Lump Sum (Tax Free Cash) above 25%? ☐ Yes ☐ No

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/GAR Annual Income

Benefit Type	Income (Per annum)	From (Date or Age)	Escalation rate	Revaluation rate
GAR	£			
GMP (Pre 06/04/1988)	£		%	%
GMP (Post 05/04/1988)	£		%	%
Section 92b Rights	£			

Annuity options

Payable
☐ Yearly ☐ Half Yearly ☐ Quarterly ☐ Monthly
☐ In advance ☐ In arrears
☐ With proportion ☐ Without proportion
☐ With overlap ☐ Without overlap

(maximums will vary by provider)

Escalation ☐ 3% ☐ 5% ☐ RPI ☐ LPI ☐ Other

Guarantee ☐ None ☐ 5 years ☐ 10 Years ☐ Other

Payable as lump sum, if possible ☐ Yes ☐ No

Value Protection % please specify the percentage of the purchase price 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

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

Participating providers

Aviva

Phone:
0800 145 5745

Email:
ENQUOTE@aviva.com

Web:
www.aviva.co.uk

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

For Data Protection enquiries,
you may contact:
dataprt@aviva.com

Aviva Life Services UK Limited. Registered in England No 2403746. 2 Rougier Street, York, YO90 1UU.

Authorised and regulated by the Financial Conduct Authority. Firm Reference Number 145452.

Canada Life

For Guaranteed Annuity Quotes

Phone:
0345 300 3199

Email:
AnnuityQuotes@canadalife.co.uk

Web:
www.canadalife.co.uk/ifazone

Post:
Annuity Quotes Team, Canada
Life Limited, Canada Life Place,
Potters Bar, Hertfordshire EN6 5BA

For Data Protection enquiries,
you may contact:
dpo@canadalife.co.uk

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For The Retirement Account Quotes

Phone:
0800 032 7689

Email:
ifaservice.ra@canadalife.co.uk

Web:
www.canadalife.co.uk

Post:
Canada Life, PO Box
4993,Worthing,BN99 4AE

For Data Protection enquiries,
you may contact:
dpo@canadalife.co.uk

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Just.

Phone:
0345 302 2287

Email:
support@wearejust.co.uk

Fax:
0345 301 2287

Web:
www.wearejust.co.uk

Post:
Enterprise House, Bancroft Road,
Reigate, Surrey RH2 7RP.

For Data Protection enquiries,
you may contact:
dataprotection@wearejust.co.uk

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Participating providers

Legal & General

Our quotes can be accessed through all whole of market research portals where we'll always provide our best price first time.

By inputting the information gathered on this form through a portal, you will be able to quickly compare quotes from across providers.

If you have any specific requests or need additional support, please contact our quote specialists using the details below.

Phone:
0345 071 0040

Email:
Broker.AnnuityQuotes@landg.com

Website:
www.legalandgeneral.com/adviser/retirement/contact-us/retirement-income/

For Data Protection enquiries, you may contact:
Data.Protection@landg.com

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Scottish Widows

Our quotes are available through the following portals:

IRESS, iPipeline, HUB, AMS Retirement, Synaptic and Retirement Line.

The information gathered on this form can be entered into these portals in order to complete a whole of market search and obtain a guaranteed quote from us.

If you do not use one of these portals you can send this completed form to annuityquotes@scottishwidows.co.uk and we will return a quote to you. Please detail the following information in your covering email – Scottish Widows Agency Number, if this is an Open Market Option (OMO) or Transfer (IVPP), and a breakdown of the multiple funds that make up the purchase price and where they are coming from if applicable. Please note this process is only available for cases with a purchase price over £75,000.

All supporting documents that you require will be returned with our guaranteed quote. For further information on our annuities, please visit our website: https://adviser.scottishwidows.co.uk/products/annuities/individual-annuities/

Data Protection enquiries:
If you have any questions, or want more details about how we use your personal information, please visit www.scottishwidows.co.uk/legal-information/legal-and-privacy/

Or you can call us on 0345 845 0099, lines are open Mon to Fri 8am - 6pm.

Calls may be monitored or recorded.

Scottish Widows Limited is registered in England and Wales No. 3196171. Registered office in the United Kingdom at 25 Gresham Street, London EC2V 7HN. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register number 181655.

Privacy Notice

All the Product Providers; Aviva, Canada Life, Just, Legal & General and Scottish Widows, 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

Scottish Widows
www.scottishwidows.co.uk/legal-information/legal-and-privacy/

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 on pages 22-23 of this form or 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