Annuities

Your Medical Details

Important

This form is critical in determining the level/amount of annuity you could receive. Please ensure you answer all the questions (and supplementary questionnaires – where applicable) as fully as possible.

For help completing this form please speak to your financial adviser

Contact Details

IFA Sales Support Tel: 0845 302 2287

IFA Sales Support Fax: 0845 301 2287

Lines are open Monday – Friday, 8.30am to 5.30pm.

Alternatively you can email us:

ifasupport@justretirement.com

Or, log onto our website for further information.

www.justretirement.com

We can help you get more money for your customers, quickly and easily.

For additional quotations this form is available for download at

www.justretirement.com/<insertlocation>

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Please complete all boxes

A Personal details

	About you	About the 2nd Applicant/Dependant
Full name		
Address		
	Postcode	Postcode
Date of birth (DD/MM/YY)		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Marital status	☐ Single ☐ Married ☐ Civil Partner ☐ Separated ☐ Divorced ☐ Widowed	☐ Single ☐ Married ☐ Civil Partner ☐ Separated ☐ Divorced ☐ Widowed
Height (cm or ft & ins)	cm ft ins	cm ft ins
Weight (kg or st & lbs)	kg st lbs	kg st lbs
What was your main occupation before retirement?		

B Lifestyle conditions

	About you	About the 2nd Applicant/Dependant
1. Are you currently a smoker and have been for the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No

2. Please advise the average number of

	About you	About the 2nd Applicant/Dependant
a) Manufactured cigarettes you smoke per day		
b) Cigars (please state type and size) OR ounces/grams of pipe tobacco you smoke per day	Cigars Pipe oz gr	Cigars Pipe oz gr
c) Ounces/grams of rolling tobacco per week	oz gr	oz gr

3. How many units of alcohol do you drink weekly?

If you consume in excess of 36 units per week please complete the supplementary questionnaire on page 7. (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)

4. If you suffer from high blood pressure please advise

a) Names of prescribed medications taken specifically for high blood pressure per day

5. If you suffer from high cholesterol please advise

a) Names of prescribed medications taken specifically for high cholesterol per day

C Medical conditions — About you — About the 2nd Applicant/Dependant

Please give full name of medical condition(s) suffered both past and present and answer all applicable questions 1-5 and a supplementary questionnaire if applicable.

	About you	About the 2nd Applicant/Dependant
Condition 1	☐	☐
Condition 2	☐	☐
Condition 3	☐	☐

Tick as appropriate

1. When did you last suffer symptoms or receive medication/treatment for this condition?

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Ongoing/within last 6 months	☐	☐	☐	☐	☐	☐
b) 6 months-2 years ago	☐	☐	☐	☐	☐	☐
c) 2-5 years ago	☐	☐	☐	☐	☐	☐
d) More than 5 years ago	☐	☐	☐	☐	☐	☐

2. How long have you suffered from this condition? When were you first diagnosed?

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) 0-1 years	☐	☐	☐	☐	☐	☐
b) 1-5 years	☐	☐	☐	☐	☐	☐
c) 5-10 years	☐	☐	☐	☐	☐	☐
d) More than 10 years	☐	☐	☐	☐	☐	☐

3. When did you last receive hospital treatment for this condition (as an In or Out patient)?

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Never	☐	☐	☐	☐	☐	☐
b) 0-1 years ago	☐	☐	☐	☐	☐	☐
c) 1-5 years ago	☐	☐	☐	☐	☐	☐
d) More than 5 years ago	☐	☐	☐	☐	☐	☐

4. What treatment have you received in the last 2 years for this condition?

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Nothing	☐	☐	☐	☐	☐	☐
b) 1-2 different prescribed medications daily	☐	☐	☐	☐	☐	☐
c) 3+ different prescribed medications daily	☐	☐	☐	☐	☐	☐
d) Special treatment e.g. Surgery Radiotherapy, Chemotherapy or Renal Dialysis	☐	☐	☐	☐	☐	☐

Please list the names of all current medications: This will assist us in establishing the best rate available to you and avoid the possibility of duplication of medication. Should this be insufficient space please use a separate sheet.

5. Concerning your mobility, in respect of this condition are you?

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
a) Fully independant	☐	☐	☐	☐	☐	☐
b) Able to walk only with assistance, e.g. stick/frame	☐	☐	☐	☐	☐	☐
c) Permanently and irreversibly wheelchair bound	☐	☐	☐	☐	☐	☐
d) Permanently and irreversibly in need of daily nursing care	☐	☐	☐	☐	☐	☐
e) Permanently and irreversibly bedridden	☐	☐	☐	☐	☐	☐

If you have answered b-e on the above, please completed the questionnaire on page 9

If you or the 2nd Applicant/Dependent suffer from any of these conditions you must also complete the relevant supplementary questionnaire

Condition		
Diabetes	☐	You must complete page 4
Heart condition	☐	You must complete page 5
Cancer, growth or tumour	☐	You must complete page 6
Leukaemia, Hodgkin's disease, Lymphoma	☐	You must complete page 7
Respiratory disease	☐	You must complete page 7
Stroke (TIA/CVA)	☐	You must complete page 8 & 9
Multiple sclerosis	☐	You must complete page 8 & 9
Dementia and Alzheimers'	☐	You must complete page 8 & 9
Activities of daily living	☐	You must complete page 9

Diabetes

☐ **Annuitant** ☐ **Dependant**

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

Type of diabetes ☐ Type 1 ☐ Type 2

What type of diabetes do you have?

- ☐ Controlled by diet only
- ☐ Tablet Controlled diabetes (How many different tablets do you take per day?) ☐
- ☐ Insulin dependant diabetes (How many times do you take insulin per day?) ☐
- ☐ Diabetes insipidus

Do you have any of the following related conditions due to your diabetes?

- ☐ Kidney disease
- ☐ Eye disease
- ☐ Heart disease
- ☐ Poor circulation

Diabetic control

- ☐ Good (HbA1C<7)
- ☐ Fair (HbAaC 7-9)
- ☐ Poor (HbA1C>9)

Do you have or have you had any of the following?

- ☐ Diabetic retinopathy
- ☐ Diabetic neuropathy
- ☐ Diabetic nephropathy
- ☐ Documented coronary artery disease or history of coronary bypass
- ☐ Severe peripheral vascular disease
- ☐ Cerebrovascular disease with history of Transient Ischaemic Attack (TIA) or Stroke

If eye disease with retinopathy, what is the stage of your retinopathy?

- ☐ Stage I retinopathy (mild, e.g. microaneurysm)
- ☐ Stage II retinopathy (moderate, e.g. spot haemorrhage)
- ☐ Stage III or IV retinopathy (severe, e.g. proliferation, neo vascularisation, macular oedema)
- ☐ Not known

What is the level of your proteinuria/albuminuria?

- ☐ Mild proteinuria (<30 mg/L)
- ☐ Moderate proteinuria (30-300 mg/L)
- ☐ Macro albuminuria (>300 mg/L)
- ☐ Not known

What stage is your nephropathy?

- ☐ Mild chronic renal failure GFR or creatinine clearance 60-89 (mL/min per 1.73m^2)
- ☐ Moderate chronic renal failure GFR or creatinine clearance 30-59 (mL/min per 1.73m^2)
- ☐ Severe chronic renal failure GFR or creatinine clearance 15-29 (mL/min per 1.73m^2)
- ☐ End stage chronic renal failure GFR or creatinine clearance <15 (mL/min per 1.73m^2)
- ☐ GFR and creatinine clearance not known per 1.73m^2)

Heart Conditions

☐ **Annuitant** ☐ **Dependant**

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

Please specify condition ____________

Do you have any of the following?

- ☐ History of single infarction (heart attack)
- ☐ History of multiple infarctions (heart attacks)
- ☐ History of interventional procedure, i.e. angioplasty, stent
- ☐ History of bypass surgery

Have you suffered any of the following?

- ☐ Cardiac failure
- ☐ Arrhythmia (please give type) ____________
- ☐ Blackouts
- ☐ Ischaemic heart disease

Functional Capacity (NYHA or ejection fraction)

- ☐ NYHA1 (EF>55%)
- ☐ NYHA2 (EF40-54%)
- ☐ NYHA3 (EF30-39%)
- ☐ NYHA4 (EF<30%)

Does your heart condition affect you in any of the following ways?

	Never	Occasionally	Always
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	☐	☐	☐

Cancer/Tumours - If cancer has been located in more than one area, please complete a questionnaire for each

☐ **Annuitant** ☐ **Dependant**

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

Site of tumour

Date of diagnosis ☐☐/☐☐/☐☐☐☐

Was the tumour ☐ Benign ☐ Malignant

Do you, or did you at the time, have any of the following?

- ☐ Carcinoma in situ
- ☐ Stage 1 disease (T1-T2, N0, local growth only)
- ☐ Stage 2 disease (T1-T2, N1, spread to local lymph nodes)
- ☐ Stage 3 disease (T1-T4, N0-N2)
- ☐ Stage 4 disease (metastatic disease, spread to distant organs)
- ☐ Recurrence of disease (in the same site)
- ☐ Radiotherapy
- ☐ Chemotherapy

In the case of Skin Cancer, please give depth or Clark level if known

In the case of prostate cancer, please advise where known

Gleason Score <5

Gleason Score 5-7

Gleason Score 8-10

Gleason Score not known

Has there been any spread of the tumour?

☐ Yes ☐ No ☐ Not known

If yes, please describe where the tumour spread to other organs/lymph nodes. Please specify where to, date of diagnosis, treatment and all hospital visits and any current symptoms.

If there is anything further you feel is relevant (particularly staging information or location of any spread) please describe on a separate sheet and/or attach any copies of doctor letters, hospital reports etc.

Leukaemia/Lymphoma/Myeloma

☐ **Annuitant** ☐ **Dependant**

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

Please specify condition

Do you have or have you had any of the following?

History of relapse or recurrence (please give details and dates)

☐ Stage 1 Disease
☐ Stage 2 Disease
☐ Stage 3 Disease
☐ Stage 4 disease (Not Myeloma)
☐ B symptoms (Lymphoma)
☐ Impaired Renal Function (Myeloma)

Supplementary Questionnaire

Respiratory Disease(s)

☐ **Annuitant** ☐ **Dependant**

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

Please specify condition

Do you have or have you had any of the following?

☐ Minimally impaired respiratory function (FEV1>70%)
☐ Moderately impaired respiratory function (FEV1 50-70%)
☐ Severely impaired respiratory function (FEV1< 50% of standard)

Or any of the following

☐ Minimally impaired vital capacity (VC>70%)
☐ Moderately impaired vital capacity (VC 50%-70%)
☐ Severely impaired vital capacity (VC<50%)

Do any of the following apply

☐ Recurrent respiratory infections
☐ Need for home oxygen
☐ Signs of cor pulmonale (right heart failure due to lung disease)

Supplementary Questionnaire

Alcohol Consumption

☐ **Annuitant** ☐ **Dependant**

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

Do you have any of the following?

☐ Fatty Liver
☐ Liver cirrhosis
☐ History of Pancreatitis
☐ Chronic gastritis
☐ History of one or more bone fractures
☐ Continued excess alcohol consumption

Stroke/Transient Ischaemic Attack (TIA)/Cerebrovascular Accident (CVA)/Subarachnoid Haemorrhage (SAH)

☐ Annuitant ☐ Dependant

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

Please specify condition ______

Please answer the questions below and complete the Activities of Daily Living questionnaire on page 9
Do you have any of the following?

- ☐ History of more than one stroke
- ☐ Frequent bladder or respiratory infections
- ☐ Pressure sores
- ☐ Progressive disease
- ☐ Visual or speech impairment
- ☐ Poorly controlled blood pressure (please give latest reading) ______
- ☐ Dementia
- ☐ Carotid artery stenosis
- ☐ Thrombo embolic disease

Supplementary Questionnaire

Multiple Sclerosis

☐ Annuitant ☐ Dependant

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

Please answer the questions below and complete the Activities of Daily Living questionnaire on page 9
Do you have any of the following?

- ☐ Bladder involvement
- ☐ Secondary infection (e.g. pneumonia)
- ☐ Brain stem involvement
- ☐ Frequent use of IVI prednisolone

Supplementary Questionnaire

Dementia and Alzheimers'

☐ Annuitant ☐ Dependant

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

Please specify condition ______

Please answer the questions below and complete the Activities of Daily Living questionnaire on page 9
Do you have any of the following?

- ☐ Continued deterioration over the years
- ☐ Signs of drug resistance
- ☐ Paralysis
- ☐ Mild dementia
- ☐ Moderate dementia
- ☐ Severe dementia
- ☐ Seizures
- ☐ On-off phenomenon
- ☐ Pneumonia
- ☐ Pneumonia within the past 12 months

Activities of Daily Living (ADL)

☐ **Annuitant** ☐ **Dependant**

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

Name of condition ____________________

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 dependent
- ☐ 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

D Declaration – Please ensure this section is completed

Just Retirement reserves the right to obtain a report from your general practitioner for each of you, to confirm the details given in this application. The policy will complete on the basis of the information that each of you have provided. If our medical investigations show that the details that make either of you eligible are incorrect, we may cancel the policies under this application or reduce the payment. Any over-payment will be recovered from you or remain your liability until recovered.

Your rights under the Access to Medical Reports Act 1988 are detailed below and we would ask that each of you having read your rights to then independantly indicate your wishes below:

Before Just Retirement may obtain a report from your doctor we are required to inform you of your rights under the Access to Medical Reports Act 1988, under which you may exercise your rights as follows;

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

You should be aware that your general practitioner can withhold the report or part of it from you if he believes you would be harmed by seeing it.

I have been advised of my rights under the Access to Medical Reports Act 1988 and consent to Just Retirement seeking medical information concerning my physical or mental health from any doctor who has attended me at any time. I consent to the release of this information to Just Retirement. I agree that a copy of this consent shall have the validity of the original.

I/We confirm that to the best of my/our knowledge and belief the above details are true and complete and this questionnaire shall form part of my application. I confirm that all facts that might be important in assessing the policies under this application have been provided. I understand that if I have failed to give all relevant facts, Just Retirement may cancel the policies under this application. If I have any doubts as to whether a fact is relevant I will disclose it.

Data Protection Act 1998 I understand that any information provided in this application, including medical details, will be held by Just Retirement and used to set up and administer the policy.

	Details about you	**About your dependant**
GP's name		
GP's address		
	Postcode	Postcode
GP's telephone number		
	☐ I do not wish to see the general practitioner's report before it is sent to Just Retirement (I am aware that I may approach my doctor with a request to see a copy of the general practitioner's report within 6 months of it's completion).	☐ I do not wish to see the general practitioner's report before it is sent to Just Retirement (I am aware that I may approach my doctor with a request to see a copy of the general practitioner's report within 6 months of it's completion).
	☐ I wish to see the general practitioner's report before it is sent to Just Retirement*	☐ I wish to see the general practitioner's report before it is sent to Just Retirement*
Print name		
Signature annuitant		
Date	☐☐/☐☐/☐☐☐☐	☐☐/☐☐/☐☐☐☐

* Your GP will allow 28 days for you to view your report prior to being sent to Just Retirement. This could delay the processing time of your application. This form is only valid for 6 months from the date of signature. If the annuity purchase has not completed in this time you will be asked to complete this form again.