

Intelligent Pensions Ltd

Medical Questionnaire

Annuity Providers offer improved terms where they consider that a person's life expectancy is reduced from the average for someone of that age. By completing this form you will enable us to obtain sample rates to determine whether you qualify for enhanced rates. If you do not complete this form we will assume that you are not suffering from any medical condition that could affect your life expectancy.

A) Personal Details:

Details About You

About your dependant

Name:

Address:

Postcode:*

Date of Birth (DD/MM/YY):*

Are you Male or Female: *

Height (ft/ins or cms):*

cms	Ft	Ins
<input type="text"/>	<input type="text"/>	<input type="text"/>

cms	Ft	Ins
<input type="text"/>	<input type="text"/>	<input type="text"/>

Weight (st/lbs or kgs):*

Kg	St	Lbs
<input type="text"/>	<input type="text"/>	<input type="text"/>

Kg	St	Lbs
<input type="text"/>	<input type="text"/>	<input type="text"/>

What was your main occupation during your working life?*

B) Lifestyle Conditions

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:*

a) Manufactured cigarettes you smoke per day

b) Cigars you smoke per day OR

Ounces/grams of pipe tobacco you smoke per day

c) Ounces/grams of cigarette tobacco you smoke per day

3. If you suffer from high blood pressure please advise:

a) BP readings POST medication (systolic/diastolic) if known

b) Number of prescribed medications taken for high blood pressure per day

4. If you suffer from high Cholesterol please advise:

a) Cholesterol level POST medication (mmol/l) if known

b) Number of prescribed medications taken for high cholesterol per day

If you have suffered any other medical condition (e.g. diabetes, cancer, heart disease) please complete section C)

C) Medical History

Please give full name of medical conditions and answer all applicable questions 1 – 8.

	Details About You	About your dependant
Condition 1	<input type="text"/>	<input type="text"/>
Condition 2	<input type="text"/>	<input type="text"/>
Condition 3	<input type="text"/>	<input type="text"/>

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
1. When did you last suffer symptoms or receive treatment for this condition?						
a) 0-6 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 7-24 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 25-60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) More than 60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. How long have you suffered from this condition?						
a) 0-12 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 13-60 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 61-120 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) More than 120 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. When were you last hospitalised for this condition?						
a) Never	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 0-12 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 13-60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) More than 60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. What treatment have you received in the last 2 years for this condition?						
a) Nothing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 1 - 2 prescribed medications daily	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 3 + prescribed medications daily	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Special treatment e.g. Surgery Radiotherapy, Chemotherapy or Renal Dialysis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please give details of prescribed medication or special treatment on the next page

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
5. Concerning your mobility, in respect of this condition are you?						
a) Fully independent	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Able to walk only with assistance, e.g. stick, frame	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Permanently and irreversibly Wheelchair bound	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Permanently and irreversibly in need of daily nursing care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Permanently and irreversibly bedridden	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D) If you have diabetes, please also answer the following questions

6. What type of diabetes do you have?		
a) Controlled by diet only	<input type="text"/>	<input type="text"/>
b) Non insulin dependent diabetes	<input type="text"/>	<input type="text"/>
c) Insulin dependent diabetes	<input type="text"/>	<input type="text"/>
7. Do you have any of the following related conditions due to your diabetes?		
a) Kidney disease	<input type="text"/>	<input type="text"/>
b) Eye disease	<input type="text"/>	<input type="text"/>
c) Heart disease	<input type="text"/>	<input type="text"/>
d) Poor circulation	<input type="text"/>	<input type="text"/>
8. If you have insulin dependent diabetes, how many times do you take insulin per day?		
a) One	<input type="text"/>	<input type="text"/>
b) Two	<input type="text"/>	<input type="text"/>
c) Three	<input type="text"/>	<input type="text"/>
d) Four or more	<input type="text"/>	<input type="text"/>
9. When were you first diagnosed with diabetes? (Please give date)	<input type="text"/>	<input type="text"/>

Additional Information

Signed _____

Date _____