Fast Track Underwriting - Customer Medical Questionnaire

Accident

Name of customer applying for cover

Date of birth dd / mm / yyyy

Application number

Financial adviser

Guide to filling in this questionnaire

1 Make sure you fill in the customer details above.

2 You should read the **important note** below about telling us about material facts.

3 Please complete the questionnaire, providing as much details as possible about your medical history.

4 Read through the answers you have given and the declaration and sign it, on the last page of this form.

Important note – Telling us about material facts

Please read the information below carefully – ask your financial adviser if you have any questions.

- You must tell us everything relevant when filling in this questionnaire. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A relevant fact (material fact) includes anything that a reputable insurer would treat as likely to influence their decision to provide insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the "further medical information" section.
- We will rely on what you tell us and you must not assume that we will automatically confirm with your GP or any other doctor any information that you provide. If relevant, you can consult your GP about the questions on this form, but we cannot cover the cost of your doctors time. You can provide any highly confidential information direct to our Chief Medical Officer in a sealed envelope and give this to your financial adviser. In these circumstances you must refer to this information when answering your health questions.
- You do not need to tell us about any genetic test (that is, analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. However, you must tell us if you are having treatment for or experiencing symptoms of a genetic condition. We may also ask you to give us full information about your family history, including all genetic conditions.
- You must tell us in writing about any change in your personal medical circumstances or family history or dangerous pursuits you take part in between the time you apply for cover and the time cover begins.

Irish Life

Accident

1 Date of accident dd / mm / yyyy

2 What sort of accident was it (for example, road-traffic accident, work-related, fall from a height, sporting injury, farm accident or other)?

3 Please describe the exact nature of the injuries you suffered?

4 Were you unconscious? Yes ◯ No ◯ If 'Yes', for how long?

5 Were you treated in hospital as a result of this accident? Yes ◯ No ◯ If 'Yes', was it:

inpatient (overnight or longer)? Yes ◯ No ◯ Date dd / mm / yyyy Details and how long you stayed

outpatient? Yes ◯ No ◯ Date dd / mm / yyyy Details

accident and emergency? Yes ◯ No ◯ Date dd / mm / yyyy Details

6 Did you consult a GP, a specialist or any hospital? If 'Yes', please give dates and how many times you went.

GP Yes ◯ No ◯ Date dd / mm / yyyy Details

Hospital Yes ◯ No ◯ Date dd / mm / yyyy Details

Specialist Yes ◯ No ◯ Date dd / mm / yyyy Details

7 What did your doctor or specialist say about your injuries or condition at the time and how you should manage it in the future?

8 Were any x-rays, scans or other investigations carried out?

Yes ◯ No ◯ If 'Yes', please give details and the results. Dates dd / mm / yyyy

Details of test

Results

9 What treatment was given or prescribed at the time (for example, stitches, medication, exercise, manipulation or surgery)?

10 How long did your symptoms last (for example, hours, days, weeks, months or longer)?

11 How long were you unable to carry out your everyday activities or off work sick as a result of this accident?

Dates dd / mm / yyyy Details

Dates dd / mm / yyyy Details

12 Does your condition affect your ability to carry out any aspect of your job or other regular responsibilities (for example, driving, lifting, carrying, bending, childminding)? Yes ◯ No ◯ If 'Yes', please give details.

Details

13 Have you now fully recovered? Yes ◯ No ◯ If 'No', please give details of any ongoing symptoms and treatment.

If 'Yes', please give details

14 Are you currently waiting for or contemplating any future investigations or to see a specialist about this condition? Yes ◯ No ◯

Details

15 Please provide any other information on this accident or your injuries which you feel may help us assess your application for cover.

Doctors and specialists you have seen

Please fill in the name and address of doctors and specialists you have seen.

Names

1

2

3

Addresses

1

2

3

Further medical information

Please use this space if you need more space to fill in your answers.

Declaration

Please review the answers given in this questionnaire and then read, sign and date this declaration.

I agree that this questionnaire will form part of my application for cover to Irish Life Assurance plc.

I have read and understood the note on the first page of this form about telling Irish Life about material facts and I understand that if I do not reveal all these facts, Irish Life could treat the plan as void and in these circumstances Irish Life will not pay a claim or refund my payments.

I have read over the answers to all the questions on this form and declare that all statements (including any statements written down for me) are true and complete. I understand a copy of this form is available to me if I ask.

I understand that this cover will not start until you have accepted me for cover and I have paid the first premium.
I understand that I must tell you in writing about any changes in my personal medical circumstances, family history or taking part in dangerous pursuits before this cover starts.

Your signature X

Date dd / mm / yyyy

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Irish Life