PENSIONS
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LIFE INSURANCE

Irish Life

FAST TRACK UNDERWRITING

CUSTOMER MEDICAL QUESTIONNAIRE - HIGH BLOOD PRESSURE (HYPERTENSION)

000046

Application Number:

Name of customer applying for cover

Date of Birth (dd/mm/yyyy)

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 date cover is accepted.

Diagnosis

1. When was your high blood pressure (hypertension) diagnosed? d d / m m / y y y y

2. Why was your blood pressure measured at that time? (for example, routine exam, due to symptoms, pregnancy, executive health check, check due to family history, life assurance medical or other)?

3. Have you ever had any tests or investigations carried out in connection with this condition? Yes ◯ No ◯

   (examples include blood tests, ECG, echocardiogram, 24-hour blood-pressure monitor, urine tests, exercise or treadmill stress test, coronary angiogram). If 'Yes', please give dates and results.

Date:	Test:	Result:
d d / m m / y y y y		
d d / m m / y y y y		
d d / m m / y y y y		

4. Do any of your immediate family (mother, father, brothers, sisters) suffer from or had any of the following before age 60 – raised blood pressure, raised cholesterol, angina, heart attack, heart disease, bypass surgery, angioplasty, stroke or diabetes?

   Yes ◯ No ◯

   If 'Yes', please list all those affected, the condition suffered and their age at diagnosis.

Relative	Condition	Age when diagnosed

Symptoms

5. Have you had any symptoms (for example dizziness, headache, chest pain, other)? Yes ◯ No ◯

   If 'Yes', please give full details including dates.

Date:	Nature of problem:
d d / m m / y y y y	
d d / m m / y y y y	
d d / m m / y y y y	

6. Do you have any related medical conditions? Yes ◯ No ◯

   (for example, raised cholesterol, raised blood-sugar levels, diabetes, kidney problems, chest pain, problems with your eyes etc)? If 'Yes', please give details.

7. Do you smoke tobacco or have you ever smoked? Yes ◯ No ◯

   If 'Yes', please give full details including the year you started smoking, the year you stopped (if this applies) and how much tobacco you smoke each day.

Year you started smoking: d d / m m / y y y y

Year you stopped smoking *(if this applies)*. d d / m m / y y y y

How much tobacco do you currently smoke or used to smoke if you have now stopped?

(number of cigarettes, cigars or ounces of tobacco)?

cigarettes	per day
cigars	per day
ounces of tobacco	per day

Treatment

8. Do you currently take medication or other treatment for this condition? Yes ◯ No ◯

(for example, Adalat, Atenolol, Capoten, Centyl K, Innovace, Zestril, Omesar or other)?

If 'Yes', please give name(s) and dosage each day.

Name(s):	Dosage each day:

Have you ever stopped taking your medication(s)? If 'Yes', why? Yes ◯ No ◯

9. Has the type of medication or dosage been changed since you began treatment? Yes ◯ No ◯

If 'Yes', please give dates and details of the changes.

Date:	Changes made:	Reason:
d d / m m / y y y y		
d d / m m / y y y y		

10. Have any future treatments or investigations been discussed? Yes ◯ No ◯

(such as changing your medication, referral to a specialist doctor, surgery or other therapy)?

If 'Yes', please give details.

11. Have you ever been treated in hospital for this or any other heart condition? Yes ◯ No ◯

If 'Yes', was it:

Inpatient? Yes ◯ No ◯ Date d d / m m / y y y y

Details and how long you stayed

Outpatient? Yes ◯ No ◯ Date d d / m m / y y y y

Details and why

Accident and emergency? Yes ◯ No ◯ Date d d / m m / y y y y

Details and why

12. **About monitoring your condition**

Who do you see to review your condition?

How often do you go for a review?

What has your doctor (and specialist, if you have one), told you about your current blood-pressure control?

When was your last consultation? Date d d / m m / y y y y

Please provide details of your last blood-pressure reading if you know.

Do not know ○ (tick if appropriate)

Date: d d / m m / y y y y

Reading:

If you were told that your blood pressure was completely normal at that time, please say this

13. Please provide any other information on this subject which you feel may be beneficial in assessing your application.

Please, outline details of any regular exercise you undertake or lifestyle changes your doctor has recommended, or you yourself have implemented as a result of your condition (for example, weight reduction, low-salt diet or other).

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 is accepted.

Please sign and date

Signature ✗

Date d d / m m / y y y y

In the interest of customer service we will record and monitor calls.
Irish Life Assurance plc is registered in Ireland number 152576, VAT number 9F55923G.