

# Fast Track Underwriting - Customer Medical Questionnaire

Crohn's disease, ulcerative colitis and gastro intestinal inflammatory disorders

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.  If any item is blank or illegible, this will cause a delay in processing your application.													
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 custome	r details above.												
2 You should read the <b>important</b> i	<b>note</b> below about telling us about material facts.												
3 Please complete the questionnain	re, providing as much details as possible about your medical history.												

### Important note - Telling us about material facts

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

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

- 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 your application is accepted.

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Di	Diagnosis	
Q1.	1. What is the exact condition that you suffer from?	
	Crohn's disease ulcerative colitis colitis proctitis	inflammatory bowel disease
Oth	Other (please name)	
Q2.	22. Do you know what part of your bowel is affected by this condition?	
	rectum only small bowel only	left sided disease
	large bowel involvement or outside the intestines	or total involvement of the colon
Oth	Other (please name)	
Q3.	3. When was the condition diagnosed?	dd/mm//yyyy
	And please describe your symptoms at the time of diagnosis	
Sy	Symptoms	
Q4.	24. Do you have any current symptoms?	Yes No
	If Yes, please describe your symptoms	
05	25. When did you last experience major symptoms?	dd/mm/VVVV
۷۶.	e.g. which required steroid treatment, A&E referral, IV fluids or hospitalisation	i.
	Please confirm the dates, symptoms and treatment required for any major epis	sodes within the last five years
06	6. What does your G.P. or specialist tell you about the current control of your co	ndition?
Qu.	you about the current control of your con	idition:
Q7.	7. Please confirm the date, type and results of the latest investigations carried ou	t in connection with the condition?
	e.g. colonoscopy	dd/mm//yyyy
08	28. Have you any associated symptoms or medical conditions?	
Qo.		nouth ulcers eye problems
Oth	Other (please name)	
	9. Have your symptoms meant you can't carry out daily duties or work?	Yes No
QJ.	Please provide dates that you have been absent from work within the past five	
	Please provide dates that you have been absent from work within the past five	eyears

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Treatment		
Q10. Do you currently take any medication or other treatments for this condition?	Yes	No 🤇
If Yes, please provide full details including name and dosage		
Q11. Have you ever been treated in hospital?	Yes	No (
If Yes, please confirm dates and details		
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212. Have you over had surgery for this condition?	Vac	N <sub>1</sub>
Q12. Have you ever had surgery for this condition?	Yes	No (
If Yes, please confirm dates and details		
Q13. Have any treatment changes been discussed, are you currently awaiting any further		
investigations, specialist review or surgery?	Yes (	No (
If Yes, please give details		
Q14. Is there any other information that you would like to include to assist our assessment?		

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

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Add	ress	es																
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### **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 application is accepted.

Please sign and date

Signature	
Date	









