

## Fast Track Underwriting - Customer Medical Questionnaire

Arthritis and other joint 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.									
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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 <b>important note</b> below about telling us about material facts.									

## Important note - Telling us about material facts

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

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

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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Q1.	What is the condition o	r symptoms that you suffer from?		
		osteoarthritis 🔵	rheumatoid arthritis	psoriatic arthritis
		gout O	ankylosing spondylitis	joint replacement
Othe	er (please name)			
O2.	When was the conditio	n diagnosed?		dd/mm/vvvv
		our symptoms at the time of diagr	nosis	
		, , ,		
_	_			
Sy	mptoms			
Q3.	What joints are affected	d?		
		ankles knees	hips hips	spine
Othe	er (please name)			
Q4.	Do you have any curre	nt symptoms?		Yes No
	If Yes, please describe y	your symptoms and how frequen	tly they occur?	
Q5.	When did you last expe	erience major symptoms?		dd/mm/yyyy
	i.e. required steroids, A	&E referral, inpatient treatment o	or an increase in medication.	
	Please confirm the date	es, symptoms and treatment requ	ired for any major episodes in t	he last 5 years
Q6.	What has your G.P. or s	specialist told you about the curre	ent control of your condition?	
Q7.	Is your mobility impaire	ed in any way?		Yes No
	If Yes, please describe h	now. e.g use of a walking stick or	walking frame	
Q8.	Have you experienced	any associated complications or s	symptoms affecting the bowel,	skin, eye, lungs or heart?
				Yes No
Q9.	Have your symptoms m	neant you can't carry out daily du	ties or work?	Yes No
	Please provide dates th	at you have been absent from wo	ork within the past five years	

**Treatment** 

Q10. Do you currently take any medication or other treatments for this condition?

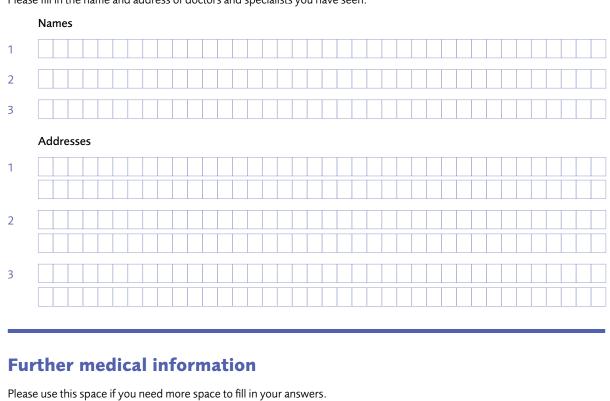
e.g bloods, scans, consultant reviews etc

If Yes, please provide full details including name and dosage. e.g. Methotrexate, Humira etc.

Q11. Please confirm the date and results of your latest investigations or review carried out regarding your condition?

dd/mm/yyyy

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



## **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	X	
Date	d d / m m /	уу

