

# Fast Track Underwriting: Customer Medical Questionnaire

## Gynaecological disorders and other conditions affecting women

Name of customer applying for cover

Date of birth

Application number

Financial Adviser

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### 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 relevant information
- 3 Please complete the questionnaire, providing as much details as possible in response to the questions 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.



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### Important note – Telling us about relevant information

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

- When deciding whether to insure you and when setting the terms and premium, we will rely on the information you have given us. You must answer all questions that we ask honestly and with reasonable care. Where we ask you to answer a specific question, the subject matter of the question is material to the risk we are undertaking or the calculation of the premium or both.
- If your answers are not true and complete, we may be entitled to void the policy without return of premium, repudiate liability, treat the policy as if it had been entered on different terms, or limit the amount paid on foot of the contract of insurance. You must tell us all relevant information when answering all of the questions. If you are not sure whether something is relevant, you should tell us anyway. We may also contact you if we need to ask you for further information on your answers or as part of any subsequent claim.
- 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 and genetic test (that is, analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. However, you must, where required by our questions, 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 answers to any of the questions in this form (for example, in relation to personal medical circumstances or family history or dangerous pursuits you take part in) between the time you apply for cover and the date your application is accepted. Failure to do this may result in a claim being refused.

## Subsection A – Hysterectomy

- 1 Have you had a hysterectomy? Yes  No
  - 2 What was the reason for it (for example, fibroid, other benign growth, prolapse, menstrual irregularities, endometriosis, adhesions, pelvic inflammatory disease, cancer or other gynaecological reason)?
  - 3 When did the surgery take place?
  - 4 Were the results totally benign (in other words, non-cancerous)? Yes  No   
If 'No', give details.
  - 5 Did you receive any further treatment after the surgery (for example radiation, chemotherapy, medication or other)? Yes  No   
If 'Yes', please give dates and details.

Dates	Details
Dates	Details
Dates	Details
  - 6 What ongoing treatment or reviews are you having?
  - 7 Please give dates and details of all immediate follow-up consultations including those with your GP or specialist and the reason for them.

Dates	Details
Dates	Details
Dates	Details
  - 8 Please give details of any future follow-up consultations or investigations that are planned and the reasons why they are needed.
  - 9 Have you been discharged from follow-up review? Yes  No   
If 'No', please give details.
  - 10 If there is any other information in relation to this condition which you feel may help us assess your application for cover, you can provide it here.
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## Subsection B – Abnormal Smear

- 1 Have you ever had an abnormal smear? Yes No  
If 'Yes', please give dates.  
Dates
- 2 Please give the result of the abnormal smear, if known (for example, borderline changes, CIN 1, CIN 2, CIN 3 or other changes).  
  
Do not know
- 3 What did your doctor or nurse tell you about the result of the smear?
- 4 Did you have any treatment or further investigations (for example colposcopy, cone biopsy, laser treatment, loop excision, LLETZ, or other)? Yes No  
If 'Yes', please give details including dates and procedure.  
Dates Procedures  
Dates Procedures  
Dates Procedures
- 5 Have you had a repeat smear since? Yes No  
If 'Yes', please give details including dates and results of all smear tests taken since the original abnormal smear test.  
Dates Details  
Dates Details  
Dates Details
- 6 Dates and details of all follow-up or review consultations done so far with your GP or specialist.  
Dates Details  
Dates Details  
Dates Details
- 7 Please give dates and details of any future follow-up consultations or investigations planned.
- 8 Have you been discharged from follow-up review? Yes No  
If 'No', please give the reasons.
- 9 If there is any other information in relation to this condition which you feel may help us assess your application for cover, you can provide it here.
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## Subsection C – Breast cysts and lumps

- 1 When did you first discover the cyst, lump or abnormality? Date
- 2 Did you have any symptoms (for example, increase in size, bleeding, change in colour, pain or other symptoms)? Yes                      No  
If 'Yes', what symptoms?
- 3 When did you first see a doctor about this and what did your doctor tell you about the lump or growth? Date  
What were you told at the time?
- 4 What investigations were carried out and by whom (for example, ultrasound, mammogram, needle aspiration, biopsy and so on)? Give dates, details and results of each one carried out.
- |       |         |
|-------|---------|
| Dates | Details |
| Dates | Details |
| Dates | Details |
- 5 If any lump or growths have been removed, please describe:
- when?
  - how (for example, local anaesthetic, general anaesthetic or other)?
  - by whom?
- 6 Do you know what it was called once removed (for example, simple cyst, benign (in other words, non-cancerous), fibroadenoma, borderline, pre-malignant, malignant tumour, cancer or other)?
- Did it come back after treatment?    Yes                      No                      If 'Yes', please give details of ongoing treatment.
- 7 Do you still have the lump or growth? Yes                      No  
If 'Yes', please give details of ongoing treatment.
- 8 Have you any other ongoing breast condition (for example, fibrocystic breast disease, mastalgia and so on)? Yes                      No  
If 'Yes', give details.
- 9 Please give the dates and details of all follow-up consultations done with your GP or specialist.
- |       |         |
|-------|---------|
| Dates | Details |
| Dates | Details |
| Dates | Details |

- |    |  |     |                       |
|----|--|-----|-----------------------|
| 10 | Have you ever been admitted overnight to hospital for this condition?<br>If 'Yes', please give dates and details.  | Yes | No                    |
|    | Dates  |     | Details               |
|    | Dates  |     | Details               |
|    | Dates  |     | Details               |
| 11 | Have you been discharged from follow-up reviews?<br>If 'No', please give reasons.  | Yes | No                    |
| 12 | Were you given any specific health advice about this condition for the future by any health professional?<br><br>If 'Yes', please give details.  | Yes | No                    |
| 13 | Before the age of 60 have any of your immediate relatives (mother, sisters and aunts) died or suffered from breast or ovarian cancer?<br><br>If 'Yes', please list all those affected, their age at diagnosis, their age now or when they died (if this applies) and the site of cancer. | Yes | No                    |
|    | Relative   |     |                       |
|    | Site of cancer   |     |                       |
|    | Age when diagnosed   |     |                       |
|    | Age now  |     | Or age when they died |
| 14 | If there is any other information in relation to this condition which you feel may help us assess your application for cover, you can provide it here.   |     |                       |

## 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.

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## Further medical information

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

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## Declaration

I understand and agree that the information I have provided in this questionnaire is material to the decision of Irish Life Assurance plc (Irish Life) to enter into the contract, on the terms and for the calculation of premium and that Irish Life has relied on this information in so doing. My contract with Irish Life comprises the plan schedule, the terms and conditions booklet and any extra rules which Irish Life head office staff may add in writing. I understand that this questionnaire will form part of my application for cover.

I have read and understood the important information about my obligation to answer all questions asked by Irish Life in this questionnaire and in connection with the application and I understand that if I do not answer these questions honestly and with reasonable care, Irish Life will be entitled (depending on the breach) to declare the plan void, refuse my claim, treat my insurance as if it was entered on different terms, or reduce my claim. If this happens, I understand and acknowledge there may be no cover under the plan, Irish Life may not refund my premiums and Irish Life may not pay a claim.

I have read over the answers to all the questions on this form and declare that all answers (including any answers written down for me) are true and complete. I declare that I have answered all of the questions in this form honestly and with reasonable care. I understand that a copy of this completed form is available to me, on request from Irish Life.

I understand that I must tell you in writing about any changes in my answers to any of the specific questions in this form (for example, in relation to personal medical circumstances, family history or taking part in dangerous pursuits) between the time I applied for cover and the date my application is accepted.

I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment.

Please sign  
and date

Your signature

Date

**Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.**