Irish Life

Fast Track Underwriting: Customer Medical Questionnaire

Bronchitis or other breathing disorders (not asthma)

Name of customer applying for cover	
Date of birth	
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 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.

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. This includes disclosing tobacco consumption or use of nicotine replacement products including e-cigarettes. 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.

Bronchitis or other breathing disorders (not asthma)

1 Please give the exact diagnosis, or nature of the condition you are suffering from or have suffered in the past (for example, bronchitis, chronic airways disease, bronchiectasis, emphysema, sarcoidosis, tuberculosis or other).

2 Please describe your ongoing symptoms.

3 How often are the attacks (for example, every day, every week, every month, once or twice a year, less often than each year)?

4 What medicines or drugs are you taking at present (for example, tablets, inhaled steroids, nebuliser or other)?

Medication or other treatment How often?

5 Have you ever needed cortisone or oral steroids (in tablets) or oxygen treatment? Yes ◯ No ◯

Date
Please state what type of treatment and for how long

Date
Please state what type of treatment and for how long

Date
Please state what type of treatment and for how long

6 Have you ever had tests or investigations carried out in connection with this condition (Examples include pulmonary function tests, chest x-rays, other scans or investigations)? Yes ◯ No ◯

If 'Yes', please give dates, tests and results.

Date Tests done
Date Tests done
Date Tests done
Results

7 Have you ever been to a respiratory clinic or chest physician? Yes ◯ No ◯

If 'Yes', please give details including dates and the outcome.

Date Details and outcome
Date Details and outcome
Date Details and outcome
Results

8 Have you ever been treated in hospital for this condition? Yes ◯ No ◯

If 'Yes', was it:

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

outpatients? Yes ◯ No ◯ Date
Details

accident and emergency? Yes ◯ No ◯ Date
Details

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

If 'Yes', give details.

10 Have the attacks ever meant you couldn't carry out your day-to-day activities or been off work sick ? Yes ◯ No ◯

If 'Yes', please give dates and details.

Dates to

Details and outcome

Dates to

Details and outcome

11 Were you given any specific health advice or suggested lifestyle changes by any health professional about this condition? Yes ◯ No ◯

If Yes, please give details

12 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 Year you stopped smoking (if this applies)

How much tobacco do you currently smoke a day, or used to a day smoke if now stopped (number of cigarettes, cigars or ounces of tobacco)?

13 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.

Further medical information

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

Declaration

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